UNITED STATES DISTRICT COURT

IN THE DISTRICT OF IDAHO

SAINT ALPHONSUS MEDICAL CENTER - NAMPA, INC., TREASURE VALLEY HOSPITAL LIMITED PARTNERSHIP, SAINT ALPHONSUS HEALTH SYSTEM, INC., AND SAINT ALPHONSUS REGIONAL MEDICAL CENTER, INC., Plaintiffs, vs. ST. LUKE'S HEALTH SYSTEM, LTD., and ST. LUKE'S REGIONAL MEDICAL CENTER, LTD., Defendants.	Case No. 1:12-cv-00560-BLW Bench Trial **Witnesses:** **David Dranove** **Kenneth W. Kizer** **James R. Polk**
FEDERAL TRADE COMMISSION; STATE OF IDAHO, Plaintiffs, vs. ST. LUKE'S HEALTH SYSTEM, LTD.; SALTZER MEDICAL GROUP, P.A., Defendants.	Case No. 1:13-cv-00116-BLW

*** * * SEALED * * ***

REPORTER'S TRANSCRIPT OF PROCEEDINGS

before B. Lynn Winmill, Chief District Judge

Held on October 21, 2013

Volume 18, Pages 3398 to 3664

Tamara I. Hohenleitner
Idaho Certified Shorthand Reporter No. 619
Registered Professional Reporter
Certified Realtime Reporter
Federal Certified Realtime Reporter

United States Courts, District of Idaho
550 West Fort Street, Boise, Idaho 83724 (208) 334-1500

A P P E A R A N C E S

FOR PLAINTIFFS SAINT ALPHONSUS MEDICAL CENTER-NAMPA, INC., SAINT ALPHONSUS HEALTH SYSTEM, INC., AND SAINT ALPHONSUS REGIONAL MEDICAL CENTER, INC.

Keely E. Duke
DUKE SCANLAN & HALL, PLLC
1087 W. River Street, Suite 300
Boise, ID 83707

David A. Ettinger
HONIGMAN MILLER SCHWARTZ AND COHN LLP
2290 First National Building
660 Woodward Avenue
Detroit, MI 48226

FOR PLAINTIFF U.S. FEDERAL TRADE COMMISSION

Peter C. Herrick
U.S. FEDERAL TRADE COMMISSION
500 Pennsylvania Ave., N.W.
Washington, DC 20580

J. Thomas Greene
U.S. FEDERAL TRADE COMMISSION
600 Pennsylvania Ave N.W.
Washington, DC 20580

Henry Chao-Lon Su
U.S. FEDERAL TRADE COMMISSION
601 New Jersey Ave., N.W.
Washington, DC 20001

A P P E A R A N C E S (Continued)

FOR PLAINTIFF STATE OF IDAHO

Eric J. Wilson
GODFREY & KAHN, S.C.
One East Main Street
Suite 500
PO Box 2719
Madison, WI 53701

Brett T. DeLange
OFFICE OF ATTORNEY GENERAL, STATE OF IDAHO
954 W. Jefferson, 2nd Floor
Boise, ID 83720-0010

FOR PLAINTIFF TREASURE VALLEY HOSPITAL

Raymond D. Powers
POWERS TOLMAN FARLEY, PLLC
PO Box 9756
Boise, ID 83707

FOR DEFENDANTS ST. LUKE'S HEALTH SYSTEM, LTD. AND ST. LUKE'S REGIONAL MEDICAL CENTER, LTD.

Jack R. Bierig
Ben J. Keith
Scott Stein
SIDLEY AUSTIN
One South Dearborn
Chicago, IL 60603

J. Walter Sinclair
Charles Schafer
STOEL RIVES
101 S. Capitol Boulevard, Suite 1900
Boise, ID 83702

FOR DEFENDANT SALTZER MEDICAL GROUP

Brian Kenneth Julian
ANDERSON JULIAN & HULL, LLP
PO Box 7426
Boise, ID 83707

I N D E X

REBUTTAL PLAINTIFFS

W I T N E S S E S

* * * * *

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P U B L I S H E D

PLAINTIFFS

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DEFENDANTS

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PROCEEDINGS

October 21, 2013

******COURTROOM OPEN TO THE PUBLIC******

THE CLERK: The court will now hear Civil Case 12-560-S-BLW, Saint Alphonsus Medical Center, Nampa, Inc., versus St. Luke's Health System for Day 18 of a bench trial.

THE COURT: Good morning, Counsel.

Mr. Metcalf I think has already discussed with you, at least, my thoughts about the two issues that came up over the weekend with regard to the plaintiffs' rebuttal witnesses. One, with regard to Dr. Polk, apparently there is a -- the plaintiffs desire to have Dr. Polk testify with regard to another medical system, electronic health records system, and I think maybe a system that plays off from that, which needs -- or which was perhaps not available or at least there has been some reason why he was not deposed on that issue.

I suggested that a -- the only appropriate resolution, given the time frame of the trial, would be to permit some type of a surrebuttal to be offered by the -- by St. Luke's, presumably, by a video deposition to be completed this week. If not, I might be able to arrange it where we could take the testimony in roughly ten days, when I would next be here in court, but I'm not sure that would be very timely. And, of course -- in any event -- and then perhaps St. Luke's would also need the opportunity to reopen the cross-examination of Dr. Polk if they could make a showing that he testified to matters they just couldn't have been prepared to respond to.

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That's my suggested resolution of that. Does counsel wish to be heard on that, or is there kind of a general agreement?

Mr. Keith, are you speaking?

MR. KEITH: I am. And in principle I think -- I think we're fine with that plan, although the timing is pretty tight with findings of fact and the like, but I think we can make that work. Perhaps after the testimony comes in we can revisit the issue depending on what he says.

THE COURT: Well, frankly, that was my thought. It may be that once you actually see what the testimony is, it may not be nearly as problematic as you think.

MR. KEITH: Correct.

MR. ETTINGER: That's fine with us, Your Honor.

THE COURT: All right. Great, Mr. Ettinger.

Now, with regard to Mr. Kee -- or, no, excuse me -- Dr. Kizer and his testimony regarding WhiteCloud, the concern I have is that unlike fact witnesses, we do require disclosure of expert witnesses by way of rebuttal because they are required by way of rebuttal expert report. I think the days of trial by ambush with regard to expert witnesses

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kind of went out with the modifications to Rule 26 and the requirement of filing reports. That's been my view, and, therefore, in general, whatever was disclosed in Dr. Kizer's expert, including his rebuttal, is what he will be allowed to testify to, and it's simply that.

Now, I'm going to give counsel a chance to put on the record either their objections to that ruling or explain perhaps why there was some misunderstanding on counsel's part that perhaps that was not the case. But that's pretty consistently been my view. That's why we allow rebuttal expert reports is to avoid that kind of surprise during the middle of a trial.

So with that --

MR. KEITH: Your Honor, that sounds sensible to us. I guess the question we have for plaintiffs is given that -- that rule where slides, the demonstrative slides 23 and part of 24, come from in the rebuttal report, we don't see anything like that in the -- in Kizer's rebuttal.

THE COURT: Mr. Greene.

MR. GREENE: Yes, Your Honor. Actually, we focus on the original report by Dr. Kizer, dated August 1st, 2013. At a high level, Dr. Kizer makes two important points with respect to WhiteCloud. Firstly, its benefits are highly speculative, and, secondly, that there are various

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alternatives with respect to this functionality. There are other products. Specifically at page 6 of his initial report, at the -- paragraph 9, at the third bullet he says, "Professor Enthoven also fails adequately to support his opinion that Saltzer would not have access to WhiteCloud or a similar data analytics tool if the acquisition were undone."

MR. KEITH: Which paragraph?

MR. GREENE: Paragraph 9.

And then -- oh, excuse me, that is the reply report. Excuse me, Your Honor.

And then with respect to this same point, at paragraph 99 of the August 1st report, the last sentence reads, "Today's" --

THE COURT: Now, is August 1st -- that's, again, the original report?

MR. GREENE: That is the --

THE COURT: Did he file a rebuttal?

MR. GREENE: That is the corrected reply. That's the reply report.

THE COURT: Okay.

MR. GREENE: The last sentence of that paragraph reads -- this is paragraph 99 -- "Today's healthcare providers can avail themselves of multiple health IT tools that perform the same basic functions as Epic and WhiteCloud

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and which can be used to support clinical integration."
So I think these slides do speak to alternatives and their comparative benefits to WhiteCloud.
I think one of the points which I know Mr. Keith has been concerned about is that, from our perspective, when we had the kerfuffle about the WhiteCloud demonstrative that Your Honor saw, we did get a demonstration the weekend before, and during the course of that demonstration, from our perspective, there are a variety of very significant admissions about its -- both its functionality and its current usefulness, which goes, from our perspective, to Dr. Kizer's view that this -- the benefits of the WhiteCloud tool are speculative.
In the alternative, in order to get in those admissions, I suppose I could call Mr. Keith, since he was the person that honcho'd that demonstration to Dr. Kizer and the rest of us. But I think it's easier and faster if Dr. Kizer can just quickly go through this slide and explain this is what he heard from Mr. Keith and Mr. Keith's expert, who was demonstrating the slide to us, the program to us. I just think it makes a lot more sense and is much more efficient.
But these are admissions; we think they're important. We think they do go to the question of whether the WhiteCloud system is speculative or not. And that was

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clearly well within the ambit of Dr. Kizer's report.
THE COURT: Mr. Keith.
MR. KEITH: Your Honor, first, I'm not sure of exactly how the admissions from my walk-through come into evidence, but the point of the walk-through was actually to show counsel exactly the slides that we were -- the screens that we were going to show through Dr. Fortuin. And it happened that Dr. Kizer was on the call. It happened that he asked a number of questions. I explained to him I was not the expert on the tool. I tried to give him the information that he asked for and only that.
So I don't think that's a reason to bring the as-yet-undisclosed rebuttal testimony of Dr. Kizer into this trial.
I think one thing that --
THE COURT: Well, he did disclose that there were alternatives to WhiteCloud and that the benefits of WhiteCloud were speculative.
MR. KEITH: So he did say that. As to the availability of alternatives, what Dr. Kizer said was there are, you know, alternatives that are equally good that are available out there in the marketplace. And we are fine with having him testify to that. He disclosed it in his report. He mentioned it in his deposition.
What we regard as undisclosed expert testimony is

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principally slide 23, where Dr. Kizer goes into what he regards as the fatal flaws of WhiteCloud: It's unknown; it's unproven; the population health tool only has so many lives; the clinical integration scorecard doesn't pull data from certain sources. None of that -- not a bit of it is in the rebuttal report.
MR. GREENE: All of that -- I think there are two levels of analysis, Your Honor. Firstly, this goes precisely to the question of the speculative nature of this product.
Secondly, Mr. Keith was not the only one on that conversation. This was a WebEx demonstration. That demonstration was handled by somebody from WhiteCloud, is my understanding of -- because I sat in on that. And so when we went through this it was explained that some --
THE COURT: Excuse me. This was done --
MR. GREENE: -- of the elements were a work in progress, other elements were not available.
THE COURT: This was done when?
MR. KEITH: Two weeks ago, Your Honor.
MR. GREENE: Two weeks ago.
MR. KEITH: We had offered to do it in May.
THE COURT: Well, I'm back where I started, whatever is in the expert report he'll be allowed to testify to. And that's essentially it. I mean, that's been my

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cardinal rule in dealing with expert witnesses for 18 years, and I don't see a reason to vary from that.
So he can offer the opinions set forth, and, you know, the slides are not of concern. I'm not going to consider anything that -- if you have part of his expert that's buried into a slide, I'll allow you to use the slide, but we're going to focus only on what's in the report. All right?
MR. GREENE: Very good. Thank you, Your Honor.
THE COURT: It would be helpful if I had a copy of that report so when we get into that, if there is any further objections, I can deal with that. When I talk about -- I mean just the paragraphs you referred to. I think it was paragraphs 9 and 99?
MR. GREENE: We'll produce a clean copy, Your Honor.
THE COURT: Thank you.
All right. Are we ready to proceed, Counsel?
MR. KEITH: Look, Your Honor, just one point.
THE COURT: Yes.
MR. KEITH: I just want to make clear for the record that I was the one doing the demonstration. As foolhardy as that might have been, it was me. And no one from WhiteCloud.
THE COURT: All right. That explains why we had

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the problem we did; right?
MR. KEITH: Apparently.
THE COURT: All right. Let's go ahead and begin. The plaintiffs may call their first rebuttal witness.
MR. HERRICK: Actually, before we get started --
THE COURT: Yes.
MR. HERRICK: -- we just have one more housekeeping matter, Your Honor.
I believe Mr. Stein is also going to have a very brief matter along the same lines. We had several exhibits from Professor Dranove's reports that were stipulated to, and we just wanted to formally move them into evidence.
THE COURT: Yes.
MR. HERRICK: And I can read them into the record whenever the court is ready.
THE COURT: How long is the list?
MR. HERRICK: It's not very long. I can do inclusive ranges if that's easier.
THE COURT: Now, you're going to have to go slow, because I have to make notes to myself as we go.
MR. HERRICK: Well, the first range is Exhibit 1772 through 1786.
THE COURT: All right. Through 1786, did you say?
MR. HERRICK: Yes, Your Honor.
THE COURT: All right. And there's no objection?

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MR. STEIN: No objection. All of the ones that Mr. Herrick is going to read we have withdrawn our objections to.
THE COURT: All right.
MR. HERRICK: The second range, Your Honor, is 1789 through 1799.
THE COURT: All right. 17 -- just so it's clear, 1772 through 1786 and now 1789 through 1799?
MR. HERRICK: That's correct, Your Honor.
THE COURT: Are admitted.
(Plaintiffs' Exhibit Nos. 1772 through 1786 and 1789 through 1799 admitted.)
MR. HERRICK: And the next range is 1802 through 1813.
THE COURT: 1802 through 1813 will be admitted.
(Plaintiffs' Exhibit Nos. 1802 through 1813 admitted.)
MR. HERRICK: And the last range is 1816 through 1827.
THE COURT: 1816 through 1827 will be admitted.
(Plaintiffs' Exhibit Nos. 1816 through 1827 admitted.)
MR. HERRICK: And I believe Mr. Stein had some exhibits he would like to offer, as well.
THE COURT: Mr. Stein.
MR. STEIN: Your Honor, for Dr. Argue, I have the following list of exhibits for which, I understand from the

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plaintiffs, the objections have been withdrawn: 2383, 2395 --
THE COURT: Okay. Just a moment. I need to turn -- all right, 2383 will be admitted.
(Defendants' Exhibit No. 2383 admitted.)
THE COURT: And 23- --
MR. STEIN: -95.
THE COURT: Admitted.
(Defendants' Exhibit No. 2395 admitted.)
MR. STEIN: 2398.
THE COURT: 2398 will be admitted.
(Defendants' Exhibit No. 2398 admitted.)
MR. STEIN: 2416.
THE COURT: 2416 --
MR. STEIN: Yes.
THE COURT: -- will be admitted.
(Defendants' Exhibit No. 2416 admitted.)
MR. STEIN: 2457.
THE COURT: 2457 will be admitted.
(Defendants' Exhibit No. 2457 admitted.)
MR. STEIN: 2460 through -65.
THE COURT: 2460 through -65?
MR. STEIN: Yes, Your Honor.
THE COURT: Those exhibits will be admitted.
(Defendants' Exhibit Nos. 2460 through 2465 admitted.)

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MR. STEIN: 2488 through 2495.
MR. ETTINGER: The list that I'm working off of, your email, starts with 2489. Oh, I'm sorry. 2488 is at the bottom of the list. Never mind, Your Honor.
THE COURT: All right, 2488 through 2495 will be admitted.
(Defendants' Exhibit Nos. 2488 through 2495 admitted.)
MR. STEIN: 2570.
THE COURT: 2570 is admitted.
(Defendants' Exhibit No. 2570 admitted.)
MR. STEIN: 2577.
THE COURT: 2577 is admitted.
(Defendants' Exhibit No. 2577 admitted.)
MR. STEIN: 2641.
THE COURT: 2641 is admitted.
(Defendants' Exhibit No. 2641 admitted.)
MR. STEIN: 2642.
THE COURT: Admitted.
(Defendants' Exhibit No. 2642 admitted.)
MR. STEIN: And, finally, 2644 through -46.
THE COURT: Okay. I assume, Mr. Herrick, that I was correct that they were stipulated to?
MR. HERRICK: Yes, Your Honor.
THE COURT: All right. Those exhibits, 2644 through 2646, also will be admitted.

(Defendants' Exhibit Nos. 2644 through 2646 admitted.)

MR. SCHAFER: Your Honor, we also have the same for Lisa Ahern.

MR. ETTINGER: Well, I'm not sure we're quite ready on those, Your Honor. We have not -- Mr. Schafer and I debated the list; Mr. Schafer is pruning down the list. We have not had time to check his pruned-down list, Your Honor. So we'll certainly get this done, but I don't think we're --

THE COURT: Before the end of the day?

MR. ETTINGER: Hopefully, Your Honor.

THE COURT: All right.

All right. Mr. Herrick.

MR. HERRICK: Plaintiffs call Professor David Dranove to the stand.

THE COURT: Dr. Dranove, would you retake the witness stand. I'll just remind you you are still under oath, having previously been sworn as a witness.

You may inquire.

MR. HERRICK: Thank you, Your Honor.

DAVID DRANOVE,

having been previously duly sworn to tell the whole truth, testified as follows:

DIRECT EXAMINATION

BY MR. HERRICK:

Q. Welcome back to Boise, Professor.

A. Thank you. It's a pleasure to be back.

Q. Professor, before we get started, did you have something that you wanted to say to the court?

A. Yes. I want to apologize for an error that appeared on slide 43 in my presentation to the court two weeks ago. The labeling on the bottom of the slide was transposed incorrectly from the slides in my original expert report, and the slides -- as a result, the labels on the back don't correspond to the correct labeling for that slide.

THE COURT: All right. Thank you.

BY MR. HERRICK:

Q. Professor, just to be clear, did the transposed labels on that slide affect your analysis or conclusions at all?

A. No. My conclusions remain the same.

MR. HERRICK: Your Honor, we would be happy to submit a corrected slide for the court's record if that would be helpful.

THE COURT: Is there any objection to that, Counsel?

MR. STEIN: No, no objection.

THE COURT: All right.

BY MR. HERRICK:

Q. Professor, have you had a chance to review the evidence presented by defendants in this case?

A. Yes, I have.

Q. And at a high level, what are your conclusions in light of the evidence defendants have offered in this case?

A. My conclusions are consistent with the conclusions I reached two weeks ago. I believe that the acquisition of Saltzer by St. Luke's will increase market concentration in an already concentrated market for primary care services in Nampa, with the result that payments from employers and employees will -- or payments by insurers then passed on to employers and employees will increase, to their harm.

Q. What about the value of competition in light of defendants' arguments?

A. Well, competition in any market is meant to lead to lower prices, greater efficiency, quality that meets the demands of consumers, and a greater number of consumers participating in the market. In healthcare that's called the Triple Aim. And I believe that competition is just as important to achieving these goals in healthcare as it is in other markets.

Q. Do you consider this transaction to be necessary for clinical integration to occur?

A. No. I believe the research evidence is, as I described last time, unambiguously ambiguous as to whether

one needs financial integration in order to achieve efficiencies or whether indeed financial integration will lead to efficiencies. And the facts on the ground, as I'll be describing later this morning, show that many provider organizations are going -- taking different paths towards trying to achieve the Triple Aim.

Q. And what about the role of market power in healthcare markets?

A. Like in any -- like in any market, market power has several short-term and long-term ramifications. It leads to a transfer of wealth from customers to producers. It also allows sellers to become entrenched. It would allow, for example, St. Luke's to potentially become entrenched and survive on the basis of its market power without the need to continually innovate in order to meet the needs of the market.

And I should say that even if the market evolves from, say, fee-for-service to risk-based contracting, you'll still have the situation of a dominant seller able to dictate the terms of the risk-based contracting, and that could lead to higher reimbursements even if the nature of the contracts changes.

Q. And do you believe, in light of defendants' arguments in this case, that the transaction is still likely to substantially harm competition?

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A. Yes, I do.
Q. Let's turn to market dynamics and competitive effects. Professor, this slide looks somewhat familiar. Can you explain to the court what this slide is showing?
A. Sure. This slide is very familiar. This lays out how prices are determined in healthcare markets and then how patients choose their providers, and it occurs in a sequence. In Stage 1 competition insurers negotiate with providers. They then assemble their networks, market their plans to employers and employees, then choose their plans, which means they choose their networks, and then they choose amongst providers within the network.
I think the really important takeaway from this -- and it's something I talked about during my earlier testimony -- is that we had a very long history in this country of having just Stage 2 competition, where there was no selective contracting. And prices during that time were very, very high and increasing at a very rapid rate. And the reason is that you just can't expect pricing pressure to be imposed by patients, for a variety of reasons. That pricing pressure comes from selecting contracting, where the insurers negotiate deep discounts and bring the prices down.
And if I'm remembering correctly, it was Professor Enthoven, when he was my dissertation advisor, who told me about the various reasons why consumers didn't make

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very -- patients didn't make very effective consumers. One reason is because they have insurance, and they're insulated against price changes.
Another reason is because prices are opaque, and we hear a lot about that in health policy circles today and even in newspaper and television coverage, that we don't have pricing transparency. It's hard for consumers to figure out the price they're paying, which makes it hard for them to comparison shop on the basis of price.
And the third reason that Professor Enthoven emphasized was that patients often make their purchases under duress. For example, when I had pneumonia two weeks ago, I wasn't going to start calling around to find the lowest-priced doctor. I needed to get care right away, so I went to the doctor I had gone to and developed a relationship with.
And for those reasons, we shouldn't expect patients to be imposing pricing discipline in the marketplace.
Q. Just to put a slighter finer point on it, Professor, why is this concept of Stage 2 versus Stage 1 competition important for your analysis of defendants' arguments?
A. Dr. Argue puts a lot of weight on his critical loss analysis. And in the critical loss analysis, all of

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the pricing pressure is coming from patients responding to price changes, and I just don't think it's realistic to expect patients to be very responsive to price changes.
Q. Thank you, Professor. We'll get to critical loss shortly. In the meantime, I just want to take a little walk through of Stage 1 competition. If you could just -- again, this looks somewhat familiar -- if you could just remind us very briefly of what this diagram is intended to show.
A. Sure. This is showing the negotiation between a health plan and St. Luke's. And we should be reminded that during the negotiation, how each party fares depends on their outside options. So the health plan, in thinking about this negotiation, is thinking if we don't have St. Luke's in our network, what will our network look like? What will our alternatives be? And in thinking of trying to attract employers that have employees in Nampa, they're going to want to have primary care coverage in Nampa, and they can still do that without St. Luke's primary care physicians, because they can have Saltzer physicians, Saint Al's physicians and other physicians.
Q. So this is the dynamic before the acquisition. Let's take a look at the dynamic after the acquisition. Defendants have made several arguments about the bargaining dynamics in this case. And, first, I just want to point your attention, Professor, to the little circle that says

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"Saint Al's." Defendants have claimed that system-to-system competition with two competitors is enough. What's your reaction to that?
A. Well, just thinking about the system-to-system competition, it may well be that in the future for Treasure Valley, there will only be two hospitals or two major hospital systems. But that doesn't mean that the residents of Nampa should only be able to choose amongst two competing primary care physician groups, a very large St. Luke's Saltzer and a small Saint Al's plus some fringe players. The fact that you have two competing hospital systems doesn't have to dictate what goes on in the primary care market.
Q. Well, now, doesn't this dynamic that we're seeing here apply only to fee-for-service contracts? I mean, you mentioned risk-based contracting. How does that fit in?
A. Again, in this negotiation, if St. Luke's and Saltzer are now merged and the outside option for the health plan is reduced, and reduced substantially because St. Luke's and Saltzer are each other's nearest competitors, that health plan is disadvantaged in negotiations.
If they're negotiating over a risk-based contract which might be based on a per-member/per-month basis, that's a contract in which the health plan pays the provider a fixed fee for each member per month that the -- the enrollee

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is choosing that provider for their care. That per-member/per-month still has to be negotiated. And a provider with market power can negotiate a higher rate.

Q. Now, let's just take a look at some of defendants' specific claims. Defendants have also suggested that a power buyer, such as a large health plan, could thwart any competitive harm. Why can't a power buyer like BCI, for example, just use its size to stop this change in bargaining leverage you're describing?

A. Well, it's certainly true that going into a negotiation each party has some leverage. One party may have more leverage than another at any given point in time. That dictates the price at any given point in time. So if you imagine the leverages here and the price is somewhere in between, what we're worrying about in this case is not the current prices. We're worried about what this merger will do to prices. Will they change? And if the merger leads to an increase in leverage for the providers, regardless of what the situation was beforehand, the providers will gain the upper hand and be able to extract higher prices in the future.

Q. So isn't absolute bargaining leverage really the determining factor in negotiations?

A. No. Again, each party brings its own level of bargaining leverage to the table. It's the relative

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leverage of the two, and as one side gains leverage relative to the other, it gains the ability to raise prices if it's a provider or lower prices if it's a purchaser.

Q. Now, you mentioned system-to-system competition in the fact that it may well be that only two hospital systems ultimately exist in the Treasure Valley. Are there any benefits you can point to of having additional competition in the Treasure Valley beyond those two health systems?

A. Sure. We'll talk later about the growth of accountable care organizations, and you heard a lot about accountable care organizations in the last two weeks. Accountable care organizations are being organized by lots of different types of organizations, including physician groups.

And if it proves out that accountable care organizations are successful and that physician-organized ACOs are successful, something that at the moment is just as speculative as the potential success of fully integrated systems. But if the physician-led systems prove to be successful, having these physicians become part of the hospital networks is going to eliminate that option for Treasure Valley.

Q. Defendants have also claimed that other providers can offset any competitive harm through, for example, excess capacity or expansion. Have you seen any evidence to

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support that?

A. Well, I have seen some evidence to suggest that that might be very difficult. We have seen Saint Al's, for example, with excess capacity --

MR. STEIN: Objection, Your Honor, I don't believe Dr. Dranove has offered any opinions concerning Saint Al's capacity or excess capacity. I know he has talked about expansion in his reports, but I don't believe he addressed Dr. Argue's opinions regarding capacity. It's not in this -- I'm sorry -- it's not in this slide, which is why --

THE COURT: Mr. Herrick.

MR. HERRICK: I believe that Professor Dranove did address excess capacity, and this was certainly an argument that Mr. -- or excuse me, Dr. Argue made. I don't have the specific cite at my fingertips. This was not an issue that came up during our discussions over the weekend.

MR. STEIN: Again, I don't mean to have this be a surprise, but the reason it didn't come up over the weekend is because I -- there's nothing --

THE COURT: It's not in the slide.

MR. STEIN: It's not in the slide.

THE COURT: Mr. Herrick, if it's going to be an opinion offered by Dr. Dranove, it needs to be in the report. So I'll just leave it at that. If you want to take

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a moment or perhaps counsel can assist you in finding that.

MR. HERRICK: Your Honor, how about I move on, and if we're able to --

THE COURT: Move on and then we can come back to it after a break.

MR. HERRICK: Sounds good.

BY MR. HERRICK:

Q. Now, Dr. Argue testified about bargaining dynamics. Did you have a chance to review Dr. Argue's testimony?

A. Yes, I did.

Q. And what was your reaction to Dr. Argue's testimony on this topic?

A. Well, I had two reactions. One was I was glad to see that he agrees with me that negotiations between providers and payors are not about any one particular service, but about the package of services or what I described two weeks ago as the bottom right-hand cell of that spreadsheet that lays out all the different payments.

I was also a little disappointed by one of the statements that he made, where he claimed that I was just taking an academic bargaining perspective on the market. My opinions are based on 25 years of conversations with people on the ground, putting together networks, negotiating with insurers, negotiating with providers. This is not something

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that I dreamed up in the ivory tower. These are ideas that were developed based on what I learned from people who were actually engaged in negotiations.

Q. Well, isn't this, more or less, just an ivory-tower construct that we're talking about here, Professor?

A. No. As a business school professor, I pride myself in getting out of the ivory tower and talking to the people who are actually doing business.

Q. Let's talk about some specific facts from this case. Dr. Argue suggested that your analysis of healthcare mergers lacked an objective threshold or cutoff, and Dr. Argue seemed to suggest that your opinion is that every merger is likely to substantially lessen competition. Is that an accurate reflection of your analysis in this case?

A. That's not at all what I believe. I used what I believe is an objective measure to assess this case and that's the change in market concentration compared with the merger guidelines. I used the merger guidelines as my threshold, and I found that this merger caused an increase in concentration that more than doubled the threshold under the merger guidelines.

Q. So just to be clear, if a merger increased bargaining leverage by a de minimus amount, would you still be concerned?

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A. I wouldn't be here.

Q. Is this merger that's before the court, in your opinion, likely to increase St. Luke's bargaining leverage by a de minimus amount?

A. No. With an increase in market concentration that's so large, I conclude that the increase in bargaining power will be substantial.

Q. Now, Dr. Argue focused on criticizing Nampa as a relevant geographic market. Is that the only market that you considered?

A. I also considered Nampa-Caldwell and Nampa-Caldwell-Meridian. And in each of those markets I also found that the increase in market concentration was well above the threshold under the merger guidelines for substantially diminishing competition.

Q. So just to be clear, let's assume for the moment -- I know you're going to disagree with this -- but if Dr. Argue is right that Nampa is not a relevant geographic market, does that change your conclusions?

A. Well, but given the geographic markets that I've considered, it would not change my conclusions.

Q. And did you review Dr. Argue's report?

A. Yes, I did.

Q. And did he calculate market shares and HHIs for various markets, just like you did?

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A. Yes. More than two dozen, and I think maybe even more than three dozen.

Q. Just at a very high level, what did Dr. Argue's market shares in HHIs show for the markets that you considered?

A. I think in the vast majority of the markets that he considered, you would also find that the increase in concentration exceeded the merger guidelines thresholds.

MR. HERRICK: Your Honor, the next slide is AEO, so if we could please blank the public screen.

THE COURT: Yes.

MR. STEIN: Your Honor, I was able to search Dr. Dranove's report, and there is some mention of the excess-capacity issue, and so I don't know precisely what he was going to say. I will withdraw my objection.

THE COURT: Thank you very much. I very much appreciate that, Mr. Stein.

MR. HERRICK: Thank you.

THE COURT: Mr. Herrick, you can either go back or not, at your option.

THE WITNESS: I recall the question, and I can just offer a brief comment.

MR. HERRICK: Okay.

THE WITNESS: I think we were talking about changes in leverage as opposed to levels of leverage. And

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the availability of capacity, were it to be important in the eyes of the bargainers, say St. Luke's and health plans, that's there even before the merger. That's already having a constraint on pricing, and that stays constant. The merger eliminates the best option for health plans. Even if this other option is out there, it eliminates the best option, and, therefore, it increases the leverage of the providers. Remember, leverage is not absolute. You never have 100 percent leverage.

THE COURT: It eliminates the best option in the sense that it takes advantage of existing excess capacity?

THE WITNESS: By "best option," I mean that St. Luke's and Saltzer are each other's best options in the eyes of the insurer trying to put together a network. Saint Al's with its excess capacity is not as good an option.

THE COURT: Oh, all right. I understand. All right.

MR. HERRICK: So, Your Honor, the next slide is AEO. If we could blank the public screen.

BY MR. HERRICK:

Q. Now, defendants have suggested that employers and other payors could resist any attempt to increase prices through narrow networks and tiering structures. Professor, as I mentioned, we've blanked the public screen for this

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slide, so at a high level and without disclosing the content of this slide to the public, can you just describe for the court how the testimony here fits into your analysis of defendants' arguments?

A. There are just two points on the screen that I'll call to your attention. The first is the bolded answer to the second bullet point, which is just a reminder that a powerful provider that's powerful enough to raise prices is also powerful enough to dictate other terms of the contract. And the other point that I'll point out is the third bullet point, which shows us that this merger could be game-changing in terms of how employers think about their networks going forward.

MR. HERRICK: Your Honor, if you would like to turn the public screen back on.

BY MR. HERRICK:

Q. Let's talk about geographic market. We have alluded to it a little bit. And Dr. Argue, as we all know, has claimed that Nampa is not a relevant geographic market. So let's focus on some evidence on that topic.

You mention, on this slide, Professor, St. Luke's physicians' testimony. I'm not going to ask you to walk through every bullet here. Do you recall any particular testimony from St. Luke's physicians that jumped out at you on the topic of geographic market?

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A. I do remember, consistently, St. Luke's physicians saying that their patients wanted to have local access. And I remember one physician who practices, I believe, right across the street from a famous ice cream parlor -- and I'm darned if I can remember the name -- in Boise, who specifically said that he did not consider Nampa physicians to be competition for his practice.

Q. And was that specifically in reference to Saltzer; do you recall?

A. Yes, that's correct.

Q. Now, you also mentioned this idea that patients prefer to have PCP services close to home. I don't think that's in dispute. But I think it's important, Professor, for you to put that into context in an antitrust sense. So can you walk the court through how that fits in.

A. I think it is the most important consideration in understanding the market and understanding something like the SSNIP test, which we use to define the market. The fact that enrollees want to have local access means that when they're signing up for their health plan, they're looking to see where the physicians are located for that health plan.

And if at the beginning of the year, you tell residents of Nampa if you sign up for this health plan, each and every time you want to get in-network primary care services you have to travel outside of Nampa for those

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services, there is going to be a lot of resistance. In fact, we heard that from the insurers. We even heard that from St. Luke's in the context of the network they're trying to put together, that you just cannot market a network that does not provide substantial local access.

Q. So you mentioned the SSNIP test. I guess just to be clear, how does this bargaining dynamic that you're talking about and the need for PCP services close to home fit into the SSNIP test?

A. Well, given the need to have local access to market your network, if, say, all of the physicians, all of the primary care physicians in Nampa went to the payor and they said, "Either give us a 5 percent pay hike or you cannot have any of us in the network," the payor is going to realize that it won't be able to market its network to employers and employees without those physicians, and it will accede to those wishes. That's the definition of the SSNIP test. By definition, because they can get a 5 percent increase, that is a well-defined market.

Q. And would the same be true if you were to expand the market to include Caldwell or even Caldwell and Meridian?

A. I think it would be even more true.

Q. Dr. Argue has claimed that his critical loss analysis suggests a much larger geographic market than

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Nampa, so let's take a look at that issue. Now, the merger guidelines mention critical loss as a potential tool; right?

A. Yes. Critical loss may be useful in some markets, but I don't believe it's useful for understanding bargaining in Stage 1 competition. I just don't think it's appropriate for this case. I'll be happy to explain why in just a moment, but I do want to add that even if you believe critical loss was appropriate, I don't believe that Dr. Argue actually performed a complete critical loss analysis, and the part of it that he did I don't believe he did correctly.

Q. Well, let's take a look at some of the details on critical loss. Focusing for the moment on your conclusion that Dr. Argue's critical loss analysis is inappropriate, can you explain why that is?

A. Sure. If you'll remember when I talked about Stage 1 and Stage 2 competition, I talked about how in the absence of bargaining, we would get prices well above current levels; that if insurers weren't engaged in selective contracting, bringing prices down to here, we would be talking about prices way up here.

So talking about how patients would impose pricing discipline, that's just not where it's at when it comes to understanding pricing in healthcare. Pricing comes through these negotiations, and, therefore, we really want to think

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about negotiations, not patient responses. Since critical loss focuses on patient responses, I think it misses the big picture.

Q. Well, you also mentioned, Professor, that Dr. Argue's analysis was incomplete. So let's talk about that.

From your perspective, did Dr. Argue implement the critical loss analysis as contemplated in the merger guidelines?

A. The critical loss analysis, as described in the merger guidelines, has two components, and Dr. Argue only did an analysis of one.

First, it requires calculating what's called the "critical loss," and that is the percentage of patients that you would have to lose to make a particular price increase unprofitable.

The second component is the calculation of the actual loss, how many patients will you actually lose if you raise your price by that amount. If the actual loss exceeds the critical loss, so the theory goes, you would not increase price because that price increase would be unprofitable.

Dr. Argue calculated a critical loss threshold, but he never calculates an actual loss. So we don't have a methodology to examine, to figure out what that actual loss would be and determine whether Dr. Argue's claim that the

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actual loss exceeds the critical loss is correct, because we don't know what he believes the actual loss is or how he has calculated it.

MR. HERRICK: Your Honor, this next slide is AEO, so if we could please blank the public screen.

THE COURT: We're going to continue on with the actual versus estimated loss? I'm curious only because I had some questions. But go ahead.

MR. HERRICK: No, feel free. We are moving to a different topic.

THE WITNESS: I do plan to say more about that in about two more slides, I think.

THE COURT: Go ahead.

MR. HERRICK: And we can certainly circle back to that issue, Your Honor.

BY MR. HERRICK:

Q. Again, Professor, we have blanked the public screen, so I'm going to ask you not to discuss any specific numbers that are on this slide. But just -- if you could explain to the court what this slide is intended to show.

A. Sure. So a critical -- no pun intended -- a critical aspect of computing the critical loss is calculating the profit margins of the seller. And to calculate the profit margins, you need to calculate what's called "variable costs." And you may remember -- I'm sure

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you've gotten at least two economics lessons on variable costs so far -- it's the amount by which the cost of the seller goes up when they sell more or when costs go down if they sell less.

But from our point of view, for this case, the seller to contemplate is St. Luke's. And I don't know -- do you see this on your monitor?

THE COURT: Yes.

THE WITNESS: So let me call your attention to the middle panel. This is one of the components, and I think the most important component. Can I make reference to the title of this panel without referring to the numbers?

MR. HERRICK: Yes.

THE WITNESS: So physician compensation is a very, very important part of the total cost to providing primary care. And from St. Luke's perspective, they are paying Saltzer physicians under the professional services agreement, essentially a fee-for-service contract. So the more those physicians provide, the more Saltzer has to pay, which makes the physician compensation a variable cost. And I believe it's virtually 100 percent variable cost. The higher the variable cost, the lower the profit margins and the higher the critical loss threshold.

Dr. Argue has used a lower variable cost that I think is inappropriate. And as a result, he gets a lower critical

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loss threshold.

BY MR. HERRICK:

Q. Now, just to be clear, Professor, and focusing solely on the critical loss calculation, what are the sort of economics of calculating critical loss?

A. So the critical loss calculation is actually an accounting exercise. It's essentially entirely based on what you believe the variable costs are. And variable costs are generally thought to be a very -- very high when you're talking about labor costs, which is why I was surprised to see Dr. Argue having such low variable cost percentages.

MR. HERRICK: Your Honor, if you could please make the screen public again.

THE COURT: Just a moment.

I just want to make sure I understood what you just testified to. You indicate that Mr. -- or Dr. Argue erred by treating the compensation to the Saltzer, or any of its physicians, as being a fixed cost rather than a variable cost?

THE WITNESS: It wasn't that extreme. He originally had one figure that was -- well, you can see the percentage on the orange bar in the figure. And the middle panel.

THE COURT: Yes.

THE WITNESS: So he was saying that physician

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compensation with that percentage fixed and that percentage variable. Then he moved on in his revision, in response to some of my concerns, to make that a bigger percentage variable, and I don't think he went far enough.

THE COURT: All right. Thank you. I just -- I was a little behind in making notes to myself. Are we ready now to turn --

MR. HERRICK: Yes, Your Honor.

THE COURT: Okay.

BY MR. HERRICK:

Q. So let's talk about what happens if Dr. Argue's assumptions on fixed and variable costs are, in fact, incorrect and what that means for the critical loss calculation. Can you just walk us through what this slide is intended to show?

A. Sure. I think there is one big takeaway from this, which is that the calculation of the critical loss threshold is very sensitive to the assumptions about variable costs. And so even as Dr. Argue makes some small changes in his assumptions, his critical loss threshold increases by roughly 30 percent, which is a very substantial increase if you're going to then try to compare that to what you think the actual loss might be.

Now, based on my experience, thinking about variable costs in a variety of contexts, including

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healthcare, I think he should have gone even further. But even here we see just how sensitive the analysis is to what the assumptions are.

Q. Professor, I'm going to ask you to suppose something that you may disagree with again, which is let's assume that Dr. Argue's revised calculations are actually correct. Can you give the court an example of why you believe and have concluded that a SSNIP would still be unlikely to cause much, if any, patient switching or PCP services?

A. I think we don't even have to do a SSNIP. We could actually take this in the context of critical loss analysis. Dr. Argue, for example, is offering for a 5 percent price increase a critical loss threshold of 8.8 percent. Now, that would be compared to an actual loss, and if the actual loss exceeds 8.8 percent, we would conclude, based on this theory, that a price increase would be unprofitable. So we wouldn't have as much to fear from this merger.

So what we want to ask ourselves is do we think that patients of primary care providers would respond to a 5 percent price increase in such a way that 8.8 percent of them would switch to another provider. And as I explained earlier, I just don't think that's likely.

Take the case of a patient who is paying $100 for

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a primary care visit. Most patients are paying a coinsurance rate. I should back up. Some patients pay fixed copayments, like $25, so if the price goes up, they don't see a price change at all. They're not going to respond. Many patients pay a coinsurance. Say the coinsurance rate is 10 or 20 percent, that $5 price increase is now a 50-cent or a $1 price increase. And they might not even know that it's a price increase because most patients have a hard time reading their medical bills, and to remember from one year to the next whether the price has gone up is going to be difficult. And even if they knew it was a price increase, if they wanted to find another doctor who was lower-priced, it's very difficult to figure out the prices of other doctors.

These are all of the arguments that, as I said, I'm pretty sure it was Dr. Enthoven who taught me many years ago all the reasons why we just don't expect patients to respond to prices. So I just don't think it's common sense to expect 8.8 percent -- which is Dr. Argue's threshold -- 8.8 percent of physicians' patients to leave them if they raise their price for primary care by 5 percent.

Q. Well, what about Dr. Argue's testimony on the so-called multiplier effect of losing patients, for example, on the inpatient side?

A. I'm glad that Dr. Argue brought up the multiplier

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effect because, once again, it reminds us that price increases can take place in any -- in any number of ways. And St. Luke's might ultimately decide to raise the price for its hospital services rather than its primary care services. We don't know where that's going to happen.

But I was also a little puzzled as I looked through the testimony of several of St. Luke's witnesses, because I saw -- I believe it was a Dr. Kaiser, who works at Saltzer, who claimed that after the acquisition he did not expect the physicians who currently refer their patients to Saint Al's will change their referral patterns, and if that's the case, there won't be a multiplier effect.

So I was hearing inconsistent testimony from different witnesses, and I didn't really know where St. Luke's stood on this issue.

Q. Well, Dr. Argue has suggested that patient-shifting in the Micron network is suggestive of how patients would respond to changes in prices. So what's your reaction to that?

A. The biggest thing to remember is that whether we're doing the critical loss calculation or a SSNIP, we're talking about price changes on the order of 5 percent. So going from $100 to $105 or from $10 to $10.50. In Micron we did see patients going to in-network or going to the most preferred tier in response to financial incentives, but

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there the magnitude of financial incentives was on the order of a 100 to a 300 percent price change. So you can't draw conclusions about the critical loss test or the SSNIP from what happened at Micron.

Q. Well, what about Dr. Argue's use of BCI and Regence data to show that patients do, in fact, travel? Why doesn't that show that the geographic market should be bigger than what you've concluded?

A. I thought that was a curious choice because when purchasing primary care within BCI and Regence, patients actually pay the same prices wherever they go. And so if they are traveling, they are not traveling in response to 5 percent price changes or in search of better prices; they are traveling for some other reason.

Q. Well, some patients are price-sensitive; right?

A. I recall Jeffrey Crouch of BCI testified that -- I think he testified that the vast majority of BCI's patients were not price-sensitive. But let's suppose that means that, say, 10 percent are price-sensitive, in order for this critical loss test to pass. In other words, for the actual loss to exceed the critical loss, we need 8.8 percent of all the patients to respond to a 5 percent price change. Well, if 90 percent are not responding because they're not price-sensitive, we need 8.8 out of 10, or 88 percent of the price-sensitive patients would have to respond to this 5

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percent price change, and that doesn't make sense to me.

Q. Now, we've talked about the facts that Dr. Argue was unable to calculate an actual loss number. Did Dr. Argue present any evidence on actual loss?

A. He didn't present any evidence on actual loss, but he did present some bar charts that, I suppose, one might think might be related to actual loss until you look very carefully at what's going on. I'll just call your attention to a couple of these bars; we can talk about all of them.

But let's take, for example, the Amednews survey on the top panel, which shows that upwards of 20 to 23 percent of the individuals surveyed did not have a usual source of care. Now, I don't know how one goes from that to a statement about how many patients of Saltzer or St. Luke's are going to change physicians if Saltzer and St. Luke's raised their price by 5 percent. First, this doesn't say anything about their price sensitivity; and, secondly, patients without a usual source of care -- well, most of the Saltzer and St. Luke's patients do have a usual source of care, so this sample just isn't relevant to understanding Saltzer and St. Luke's.

And I'll just give you another example. The Deloitte survey, in the bottom left, this shows that 13 percent of survey respondents were likely to switch PCPs. What the survey actually did was survey individuals and ask

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them if in the previous year they had switched physicians. And what they found is in 2010, 13 percent of the patients who responded had switched physicians. So in 2010, 13 percent had switched physicians.

What's interesting about the survey is they then asked the patients "Why did you switch physicians," and they gave them a lot of options. And the most popular answer, 30 or 40 percent responded, "Because I was unhappy with the quality of my physician."

One of the options that patients had was, "I switched physicians because I was unhappy with the price." It's kind of difficult to read from the write-up exactly what percentage of the respondents gave that answer. It was somewhere between 6 and 8 percent of the 13 percent. So 13 percent switched of whom 6 or 8 percent -- and that adds up to about 1 percent of all the survey respondents -- switched because they were unhappy with the price.

So based on the Deloitte survey in 2010, 1 percent of the American population switched physicians because they were unhappy with the price. That is not an 8.8 percent switching in response to a 5 percent price increase. In fact, if anything, it suggests that an 8.8 percent rate of switching is unlikely to be realized.

Q. So what conclusions can you draw from these surveys with respect to Dr. Argue's critical loss analysis?

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A. I think I'm -- I don't think that this informs us about what the actual loss is, and without any methodology to understand where Dr. Argue's getting his actual loss from, I don't know how to determine whether the actual loss will exceed the critical loss.

Q. Well, Dr. Argue also talked about patient flows and why -- actually, before I continue, Your Honor, did you have any additional questions on the actual loss issue?

THE COURT: If I understand you correctly, what you're saying is that Dr. Argue set up a model in which he assumed that in order to -- that a SSNIP would be in the 5 to 10 percent range; right? Or 5 percent?

THE WITNESS: I think there are two different models that we need to keep straight. One is the SSNIP, which is like the hypothetical monopolists. The other is the critical loss.

THE COURT: Well, where does the 5 -- the 5 percent from Dr. Argue he correlated the two, so that if --

THE WITNESS: He took 5 percent. He also did it for 10 percent.

THE COURT: Right.

THE WITNESS: Whichever percent you use -- and you could pick any number -- you then use that same percent -- so suppose he had picked 10 percent, in which case the critical loss threshold would have been 16 percent.

THE COURT: Right.
THE WITNESS: You then use the same number, 10 percent, to compute the actual loss. And you need some method for figuring out if there was a 10 percent increase, how many patients would leave this doctor.
THE COURT: Right.
THE WITNESS: And he could have chosen any particular percentage. That number is not important. I think one uses 5 or 10 percent because the merger guidelines for SSNIP seem to talk about 5 to 10 percent.
THE COURT: The critical loss depends upon the provider's own self-interest, in that they are trying to maintain profitability.
THE WITNESS: That's the idea behind the comparison of the actual loss to the critical loss.
THE COURT: But I'm trying to recall -- and, again, I'm just fuzzy right now.
THE WITNESS: I understand.
THE COURT: And that may be the difference between the theoretical and the actual, that the 8.8 percent is not -- what you're saying is that we really need to look at what the actual loss would be with boots on the ground rather than theoretically assume what the 8.8 percent would be?
THE WITNESS: That's right. So Dr. Argue, using

accounting data, has come up with the critical loss, which is 8.8 percent. We need to know what the actual loss would be. And I haven't calculated an actual loss, and Dr. Argue hasn't calculated an actual loss, either. We've heard a lot of evidence about patient price sensitivity.
THE COURT: But you think it would be far less than 8.8 percent?
THE WITNESS: No, you need to be above 8.8 percent for the price increase to be unprofitable and below 8.8 percent for it to be profitable.
THE COURT: But you would say that studies indicate that, in fact, people are not that sensitive --
THE WITNESS: That's right.
THE COURT: -- to price and, therefore, less than 8.8 percent would change their provider with a 5 percent increase in price; is that right?
THE WITNESS: Yeah. And so I would believe that, because the actual loss is less than 8.8 percent, I would expect that a price increase would be profitable.
THE COURT: Okay. Which would, again, suggest market power or the ability to influence prices?
THE WITNESS: Correct.
THE COURT: Without restraint?
THE WITNESS: Well, except the restraint of any monopolist; at some point you'll reach a price where people

say no.
THE COURT: All right.
BY MR. HERRICK:
Q. So turning to Dr. Argue's patient flow analysis -- and we've seen this slide before -- how does this fit in with Dr. Argue's testimony on geographic market?
A. I think this is a reminder of the dangers of relying on strict thresholds for patient flows to define markets, or what's called patient flow analysis, as opposed to using information on patient flows in conjunction with other facts.
So we know, for example, that 38.1 percent of the residents of Nampa left Nampa for primary care during the year for which this data was calculated. And a strict patient flow analysis would say that's too big of a number, Nampa is not a market.
But if we apply that strict threshold to what seems to be Dr. Argue's best take at what a geographic market is, though he's never -- never specifically states what he thinks the market is, that's a market that stretches from Caldwell in the west to west Boise in the east, and you get a 38.6 percent outflow. So using the same strict threshold, you would conclude that the Nampa/Caldwell/Meridian/west Boise area is not a market.
Well, let's suppose we want to make that argument.

If we're going to make that argument, we have to believe that the physicians within that area could not impose a SSNIP. Because if they could, it is a market.
Well, let's do the thought experiment. Take all the physicians between Caldwell and west Boise, have them agree to be represented by somebody in negotiations with the insurers, and the negotiator tells the insurers, "Give our doctors a 5 percent price increase, and if you don't, none of them will be in your network. You will have no doctors between Caldwell and west Boise." We know how the insurers are going to respond. They're going to say, "We have to have those doctors to have a network; if we don't, we can't market our network." They will be able to implement the SSNIP, which means that even with a 38.6 percent outflow measure, you have a well-defined market.
So these strict thresholds for outflows just cannot be used. And this is why there have been so many economics papers in the last 15 years rejecting the use of strict thresholds for doing market definition.
Q. Let's turn to defendants' efficiencies claims. Now, defendants have talked a lot about risk-based contracting and the shift from volume to value. Do you have a view of whether the transaction that's before the court is necessary to achieve those claimed efficiencies?
A. I think it's good to put this into context. A

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major feature of the Affordable Care Act is a call for the creation of accountable care organizations. And accountable care organizations are going to bear risk through what's known as a shared savings program, where providers who are able to lower the cost of care will share in the savings, and depending on how the providers choose to sign up for the program, if their costs of care go up, they could actually be penalized. They've also agreed to accept financial bonuses for meeting quality standards. So this is the -- kind of the new world we're living in, in terms of trying to change incentives.

But if you look at what's going on in ACOs, there have been a wide variety of organizations that have signed up to become ACOs. In terms of the boots on the ground, there are organizations across the spectrum, from integrated systems like St. Luke's to affiliations of physicians and everything in between that believe that they can change the way they deliver care under these new incentives.

Q. You mentioned or described ACOs. Can you just define for the court what an ACO is?

A. Sorry. An accountable care organization.

Q. Is St. Luke's, based on your understanding, a typical ACO?

A. I think what we've learned by looking at the first few hundred applicants and approved ACOs is that there is no

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typical ACO. You have independent physician groups. You have multispecialty group practices. You have large integrated delivery systems like St. Luke's.

Q. So what does that tell you about whether Saltzer or a group like Saltzer could take on risk?

A. I think if you look at what's happening elsewhere around the country, there are physician groups comparable in size to Saltzer, even groups smaller than Saltzer, that are forming ACOs, that are willing to take on risk. Now, they may not succeed. The jury is out. As I've said, the research evidence here is all over the map. But St. Luke's might not succeed either. And I think what's exciting about the next five to ten years is that we're going to see experiments all over the country, and we'll learn from those experiments and see what works.

Q. So based on this and your other analyses, does Saltzer need to become part of a larger system to be part of what's been characterized as 21st century delivery of care?

A. Saltzer could do what a lot of physician groups are doing, which is writing contracts with hospitals. They could be -- they could start an ACO. They could write a contract with a hospital, pay the hospital for the care provided at that hospital. They could even write a contract with performance standards for that hospital. I'm not saying that Saltzer is ready to do that today, but we're

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seeing this trend all around the country, and if groups are able to prove that this works elsewhere, I would expect groups like Saltzer would become very interested in this.

Q. Let's focus on some specifics with respect to Saltzer. Does the Saltzer PSA with St. Luke's encourage the kind of shift from volume to value that we've been talking about?

A. I think we always have to remember that the incentives facing an individual provider do not necessarily equate to the incentives that have been assumed by their employer. If St. Luke's has an ACO, St. Luke's will get the shared savings from Medicare or potentially commercial insurers if they decide to go with ACOs, as well. But that doesn't mean that the individual physicians are going to be in a shared savings program. And, in fact, under the current professional services agreement between St. Luke's and Saltzer, the compensation for Saltzer physicians remains fee-for-service. So that suggests that unless things change, the Saltzer doctors may not change their behavior.

Q. What about the recent amendment to the PSA? Did that change the incentives you're describing?

A. There is a discussion that 20 percent of the compensation might not be fee-for-service based. It's vague as about how that will change. I have seen contracts of quality standards given to other physicians in other markets

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where the physicians are essentially able to meet all of the quality standards without changing their current method of practice. If it goes in that direction -- and I hope it doesn't -- if it goes in that direction, then even the proposed changes won't really amount to any real change.

Q. But at this point, is there any change in the incentives that you can find in either the PSA or the amendment to the PSA?

A. No. Anything in the amendment is speculative.

Q. Now, defendants have suggested that we take a wait-and-see approach and trust them to deliver on these promises. What's your reaction to that suggestion?

A. I think it's very dangerous. And two or three slides from now we're going to see a statement from a very prestigious group of health policy experts through the auspices of the Brookings Institute, where they really explain, I think, in very clear and simple terms why it's dangerous to entrench a firm with market power during this time of uncertainty in healthcare.

Q. Well, let's suppose that Saltzer is divested. Is there a role for independent groups like Saltzer in transforming healthcare?

A. Of course, and we've seen dozens, if not hundreds, of independent physicians, independent physician groups trying to make a change in how the world of healthcare

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works. Just another example of a group that is doing their own thing to try to achieve the Triple Aim would be Primary Health, which you heard about through testimony.

MR. STEIN: Your Honor, I'm going to object. This is one of the slides that -- Dr. Dranove is about to talk about another one of the slides concerning his analysis, purported analysis of Primary Health and its quality, none of which is in any of his reports. This is -- this is now a new opinion based on Dr. Peterman's -- his interpretation of Dr. Peterman's trial testimony.

MR. HERRICK: Well, in response to testimony offered by St. Luke's, Dr. Dranove is merely using Primary Health to illustrate numerous opinions that he has offered on how an independent group, such as Saltzer or Primary Health or any number of others, could achieve integrated care and the Triple Aim. I can rattle off a handful of examples from Professor Dranove's report if that would be helpful.

MR. STEIN: I think that would be helpful, Your Honor, because I think what Your Honor will hear is that -- again, first of all, this is not illustrative; this is an opinion. It's only relevant because it's being offered as an opinion about Primary Health's capabilities and its ability to achieve the type of integration as an independent practice that Saltzer and St. Luke's are

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achieving. So it's not illustrative. It's offered for the truth of it.

And I think if -- I would be happy to hear Mr. Herrick identify the specific opinions in the report that he says this ties back to, and then Your Honor can determine whether this is fairly disclosed in Dr. Dranove's report.

THE COURT: Mr. Herrick, we're going to take a break in -- well, we could take it anytime, but in 10 or 20 minutes. Do you want to move on and come back and look to -- again, if it's in the report, you can inquire about it. The rule requires not only disclosure of the opinions, but also the bases for the opinions and, therefore, other examples should have been in the report if the -- if Dr. Dranove is going to rely upon that.

Dr. Dranove, this is not meant to fault you in any way. It's a way of trying to make sure that we are on the same page and we're not -- there's no surprise to the other side, so don't take it personal if I --

THE WITNESS: I understand, Your Honor, and I certainly don't.

THE COURT: All right. Proceed.

MR. HERRICK: Your Honor, I can speak to this issue right now if that's helpful.

THE COURT: Go ahead.

MR. HERRICK: I'll just give a few examples. For

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example, in Professor Dranove's reply report, paragraph 190, Professor Dranove wrote, "Any cost or quality improvements St. Luke's may seek to pursue within this structure, it could also pursue by working with an independent Saltzer." He has several paragraphs discussing St. Luke's efforts with independent physicians. He also cites Primary Health in a wide variety of locations in his reports; for example, he identifies Primary Health as an independent group and describes its size in relation to other physician groups. I believe he had the exact number of physicians --

THE COURT: But was it quoted in the context of Primary Health being able to, as a group of independent physicians, to fulfill the Triple Aim, as set forth in this slide?

MR. HERRICK: He did not cite Primary Health as a specific example of --

THE COURT: What was the reference to Primary Health?

MR. HERRICK: Well, for example, the very first bullet there, Professor Dranove did include Primary Health in his list of physician groups and their relative size. I believe he had the number "33" in his report. Dr. Peterman said "30" during his testimony, so we were using that. He also noted that they have multiple sites, including Nampa. You know, the specifics of the eClinicalWorks program, that

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was new information that came out during Dr. Peterman's testimony. Again, merely citing this as an example of the numerous physician groups around the country that are doing this sort of thing.

MR. STEIN: I have -- I will withdraw my objection to the first two bullet points, Your Honor. He can certainly testify about those, but the rest of this is all new. And again, Dr. Peterman, he wasn't some unanticipated witness who came in at trial. This is plaintiffs' witness. So I don't think it's really fair for them to say, well, we elicited some things from him at trial and now we're going to use that --

THE COURT: I'll sustain the objection to any new opinions that were not disclosed. The witness clearly can testify that physician groups, as I think indicated in his report as you've quoted it, in fact, have been able to fulfill the Triple Aim without this type of merger or consolidation. But using Primary Health as a specific example should have been in the report, and it should have been anticipated. So on that basis, I'll sustain the objection.

MR. HERRICK: Fair enough, Your Honor. We can move on.

BY MR. HERRICK:

Q. Let's talk about the perception, Professor

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Dranove, that integration of healthcare systems is not only a good, but perhaps a necessary good. Professor Enthoven identified some research evidence on financial integration. Have you had a chance to review that research?

A. Yes, I have.

Q. And can you just comment --

A. Sure.

Q. -- generally on what you saw there?

A. So as I stated in my initial testimony, the research literature is unambiguously ambiguous, which means there are research papers showing that financial integration has worked and others showing that it hasn't worked. So it's not surprising that Dr. Enthoven has been able to present some papers showing that it's worked. In my report, I presented some papers showing that it doesn't work. You put them together and you get that ambiguity. So I'm certainly not surprised by the fact that these papers are listed here.

Q. Have any studies that you've reviewed expressed concerns about the concentration of market power in healthcare from physician acquisitions?

A. Yes. I want to talk and close by talking about the Brookings report that I described in my expert report. This report was written by 18 of the nation's top health policy analysts from across the political spectrum. And if

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you could refresh my memory, I can remind the court the credentials of some of these coauthors.

Q. Sure, sure. I'll throw some names at you, and you just let the court know who these folks are. Donna Shalala?

A. Donna Shalala was former secretary of Health and Human Services under President Clinton.

Q. Michael Leavitt?

A. Secretary of Health and Human Services under the second President Bush.

Q. Mark McClellan.

A. Mark McClellan was the director of the Centers for Medicare Services under the second President Bush.

Q. Is that CMS?

A. CMS.

Q. David Cutler?

A. David Cutler is a renowned economist and one of the principal architects of the Affordable Care Act for President Obama.

Q. Tom Daschle.

A. Tom Daschle, the Democratic former Senate majority leader.

Q. Steve Shortell?

A. Steve Shortell, perhaps less renowned than some of the others, the dean of the Berkeley School of Public Health. I mention him because he is the coauthor of the

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Gillies paper that was one of the three papers that you referenced on the previous slide.

Q. Okay. Let me bring that back up. So this is the --

A. The second --

Q. Just to clarify, can you just clarify what you're talking about here?

A. Yes. So he's one of the coauthors of the papers that found evidence that organized delivery systems, like St. Luke's, were doing a good job. Even so, these 6 authors and the other 12 coauthors, none of whom were slouches -- three had positions, top positions in presidential administrations. They come from across the political spectrum. There is no axe to grind here, politically. This is a cross-section of views. And I think their quotes speak for themselves. They say that policymakers should enhance the current antitrust enforcement practice of imposing higher standards and greater scrutiny for mergers relative to contracts.

I think the second bullet point here is really important: "It's easier to modify or undo contractual relationships than full integration." And, boy, have we learned this in the field of strategy, how firms with market power can become entrenched, and then they rely on their market power to survive in the marketplace without

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innovating, without meeting the needs of their consumers.

We're not saying that's what's going to happen for fully integrated systems. At this point we just don't know. And if we approve these -- when we know they're creating market power, if we approve them because we hope that they're going to create efficiencies, and we prove to be wrong five, ten years from now, and maybe much longer, the markets in which we have approved these will be entrenched, dominant systems. And what the Brookings report is telling us is that we need to tread carefully. We have to make sure that doesn't happen.

Q. So the title of this study was, "Bending the Curve." Is that correct?

A. Yeah. And "bending the curve" is yet more health industry jargon. It's very similar to the Triple Aim. So if you imagine the cost curve and costs going up every year, we want to reverse that, get the curve to start slowing down and even reversing so that we can have lower costs and more access for everybody.

Q. So, Professor, in light of defendants' arguments, what are your conclusions in this case?

A. My conclusions remain the same. Nampa is a relevant geographic market. This merger creates additional concentration in an already concentrated market that will substantially increase St. Luke's bargaining power to the

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detriment of consumers. There is hope that we could figure out how to change the way we deliver healthcare so that we can create efficiencies and achieve the Triple Aim.

And full integration, such as what St. Luke's is shooting for, may ultimately be one of many successful ways of doing that. It might be the only successful way. It might be completely unsuccessful. But the jury is out on that. And as the Brookings study reminds us, other ways of organizing care could prove to be successful and that full vertical integration could be hard to undo, in which case we'll be stuck with the dominant provider with none of the benefits that we were hoping for.

Q. Professor, have you heard the phrase "no proof of concept"?

A. Yes, I have.

Q. What does that mean?

A. Proof of concept is when we've got a theory, and it sounds good, but we're still waiting for the evidence. And when it comes to fully integrated delivery systems, we've had that theory for 20 years, and there is still no proof of concept.

MR. HERRICK: Thank you. I have no further questions at this time.

THE COURT: Mr. Stein, do you want -- I'll give you the option: We either start now or take a 15-minute break.

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MR. STEIN: Why don't we take -- if we're going to be taking our normal morning break, why don't we take it now.

THE COURT: All right. Counsel, let's take a 15-minute break. Today is going to be a little bit different because I'm not sure when we're going to end, so I'm trying to space out the breaks maybe a little bit differently or at least give us some flexibility in that regard.

All right. We'll be in recess for 15 minutes.

(Recess.)

****** COURTROOM REMAINS OPEN TO THE PUBLIC ******

THE COURT: Dr. Dranove, I'll remind you that you are still under oath.

Mr. Stein, you may examine the witness.

MR. STEIN: Thank you, Your Honor.

CROSS-EXAMINATION

BY MR. STEIN:

Q. Good morning again, Professor Dranove.

A. Good morning, Mr. Stein.

Q. We're looking at slide 6 of your rebuttal demonstrative. I believe the point you have made repeatedly is that one reason this transaction is likely to have anticompetitive effects is not just because of the concentration, but because when you do your diversion analysis, you see that Saint Al's is the third-most preferred choice of residents behind St. Luke's and Saltzer; is that right?

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A. I think in my -- the way I would put it is that St. Luke's and Saltzer are each other's closest competitors, so Saint Al's would be next after those.

Q. Isn't it a fact that your own diversion analysis shows that for Nampa residents who use Saltzer, that the difference between Saint Al's and St. Luke's as a second and third choice is the difference between 15 percent and 12.3 percent?

A. I seem to recall that if you restrict it to within the choices within Nampa, you would get numbers like 15 and 12 and a fraction. But then if you go outside of Nampa and include other St. Luke's providers, the difference becomes bigger.

Q. Right. But when you talk about including providers outside of Nampa, what you're suggesting is it would be appropriate then -- you're saying that if patients couldn't have access to Saltzer in Nampa, they would actually go to providers in other communities, surrounding communities, rather than going to Saint Al's or St. Luke's in Nampa; is that right?

A. Yeah. We had this conversation during our last time we talked about what goes on in diversion analysis. So we're taking people out of the market, and they may go elsewhere.

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Q. And that difference between 15 percent and 12.3 percent, is that a significant difference between those two figures in your mind?

A. It's not meant to be an issue of the magnitude of the difference. And, in fact, even if they had been the third-best option, that would still be taking away a very important option for the bargain. If you're taking the second-best option away, it takes an even more important option.

Q. When you say "if they had been the third-best option," you mean St. Luke's?

A. Yes, yes.

Q. So let's take a look at slide 8 of your demonstrative. I'm interested in the title here, "Antitrust analysis focuses on changes in provider leverage."

In fact, Dr. Dranove, isn't it true that what the antitrust analysis focuses on is market power; right?

A. In my opinion, the purpose of antitrust analysis is to predict the outcome of a transaction. Antitrust analysis is predictive.

Q. So would you disagree with the statement that the focus of the antitrust analysis is to determine whether the

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transaction creates or enhances market power?
A. It may be that in making that prediction, we might want to focus our analytic tools on an analysis of market concentration or market power or, in a bargaining context, on an analysis of how the deal will affect leverage.
Q. Well, but you testified last time you were here, Dr. Dranove, a change in leverage doesn't tell you whether the provider has or will obtain market power; right?
A. The -- I want to make sure we've got cause and effect. Attaining or increasing market power gives you an increase in leverage.
Q. Right. But getting an increase in leverage doesn't necessarily give you market power?
A. Getting an increase in leverage will give you an ability to raise price that's proportional, more or less, to the increase in leverage. So it could be very, very small, or it could be substantial.
Q. Right. And that would be true even if the provider doesn't have market power --
A. That's correct.
Q. -- right?
And the reason market power is important, not just changes in leverage, is because market power is what gives an entity the ability to raise price above competitive levels; right?

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A. I'll agree with that statement.
Q. Now, Dr. Dranove, you emphasized a couple of times in your testimony the importance of facts on the ground. You agree that's important to have facts -- to understand the facts of the case --
A. Yes.
Q. -- right?
And as somebody in this field, if you've got a theory, one way you want to test your theory is to examine the facts on the ground and see whether it's borne out; is that right? It's important to try to do that?
A. That's sometimes done. It's sometimes an important part of an inquiry. Sometimes theoretical development can be very important in its own right.
Q. Is there a reason in this case it wouldn't be appropriate to look at any of the facts on the ground that you had access to in order to determine whether they would support your theories?
A. I think it would probably depend on the specific application you have in mind.
Q. Well, one of the things that you have talked about is the fact that this acquisition of the Saltzer practice is one of a number of practices that St. Luke's has acquired over the last five or six years; is that right?
A. Yes, that is.

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Q. And under your theory, the acquisitions of those other practices would have enhanced St. Luke's bargaining leverage vis-a-vis payors; is that right?
A. To either a small or a large extent, yes.
Q. Right. And you didn't examine the extent to which those -- any of those prior acquisitions changed St. Luke's bargaining leverage or the degree to which it changed the bargaining leverage; correct?
A. That's correct.
Q. And you didn't, therefore, do any analysis to demonstrate whether any of those prior acquisitions actually led to an above competitive price increase; is that right?
A. That's -- so when I looked at the efficiency claims, I looked at simultaneous effects on prices and quantities, so I did not sort out price effects.
Q. And even though we heard testimony that Blue Cross modeled the impact of the Saltzer transaction when it agreed to the rates in the current contract with St. Luke's, you didn't examine the pricing -- St. Luke's current pricing with Blue Cross to determine whether it's supercompetitive; correct?
A. Actually, I did do that analysis.
Q. Is it in your reports?
A. No, it's not.
Q. In fact, you didn't even look at any of St. Luke's

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contracts with payors before you reached your conclusions; is that right?
A. I did not look at contracts.
MR. STEIN: If we can go -- Your Honor, if we could turn off slide 11, I think Mr. Herrick had indicated this was attorneys' eyes only.
THE WITNESS: It's black -- there it is. Okay. Thank you.
BY MR. STEIN:
Q. Micron has very few employees who use Nampa physicians today; is that right?
A. I believe that's correct.
MR. HERRICK: Your Honor, this particular slide, I just want to caution that the specifics of this slide, including the firm, were not disclosed. And we would ask that, to the extent possible, that it not be disclosed during the questioning.
THE COURT: Mr. Stein, if you feel it's necessary, we can clear the courtroom.
MR. STEIN: I don't think anything I'm going to be asking here is --
THE COURT: My concern is that I don't believe there is an attorney here for the party whose AEO this is. So I think we need to be very -- kind of tread carefully in that regard.

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MR. STEIN: I think what I'm going to cover is not AEO, or if it is going to get to AEO, maybe I'll save it to the end if that works.

THE COURT: All right.

MR. STEIN: I'll tell you what, Your Honor. We can move to a different topic, and we can come back to this at the end.

THE COURT: All right. Thank you very much.

BY MR. STEIN:

Q. Let's talk a little bit about the critical loss analysis. Now, your view, Dr. Dranove -- I think you have pretty well established it this afternoon or this morning -- is that you don't think patients are particularly sensitive to price; right?

A. That's correct.

Q. So it really doesn't matter what the critical loss amount is; it's not likely to affect your conclusions about -- any of your conclusions; is that right?

A. In terms of my conclusions towards the impact of this case, that's correct, both because I think -- I suppose if one had found a very, very small critical loss, I might have found that the actual loss might be greater. But also, as I described in my expert report, I think there is some internal inconsistencies with critical loss analysis that would call into question any of the results.

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Q. And you have not done any independent analysis yourself to try to ascertain how sensitive residents in the Treasure Valley or Nampa residents are to changes in price; right?

A. That's right. I don't believe there was a natural experiment in the data that would have allowed me to do that.

Q. Well, we know that in this market, Micron implemented price incentives to incentivize providers to choose -- I'm sorry -- patients to choose as between certain tiers of in-network providers; right?

A. That's correct.

Q. And you decided not to look at that data and determine the extent to which those price incentives or the level of those price incentives are what led patients to switch physicians; is that right?

A. So those price changes, as we discussed, were on the magnitude of 100 to 300 percent price changes. And it would be, I think, inappropriate statistics to try to draw inferences about 5 percent price changes from 100 price changes. And that would be -- that would be basically trying to estimate out of sample, so to speak.

Q. That's why you chose just not to look at the data; right?

A. It would be inappropriate to do so.

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Q. It would be inappropriate --

A. From a statistical -- from a statistical perspective, it would be inappropriate to try to make a claim about a 5 percent price change from a response to a 100 price change. That kind of extrapolation just normally would not be done in statistical analysis.

Q. Now, any -- well, in order to understand whether it was really a 100 percent price change because you're talking about -- you would have to understand what the price differences were or the charge differences were between the providers; right? They are not all charging the same thing?

A. To a first-order approximation, the 10 percent versus 20 percent copayment is what's determining the price differences. The variation within a tier will be probably much smaller than that 100 percent difference.

And also, patients generally, as we discussed two weeks ago, they respond to the tiering to the percentages. They tend not to even see the price differences within a tier.

Q. Well, perhaps that may be true, but you certainly can't say that based on the Micron data because you didn't look at it; right?

A. I did not look at the Micron data.

Q. Now, when we're talking about the actual loss portion of the critical loss analysis, there are multiple

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ways that an attempted price increase can cause a provider to lose revenue; right?

A. I -- I have in mind a couple. I don't know what you have in mind.

Q. Well, for example, if a -- if St. Luke's implemented a price increase and that caused patients in Nampa to switch to other non-St. Luke's providers in Nampa, that could cost St. Luke's revenue; right?

A. That's correct.

Q. And if a price increase caused patients who currently travel from Nampa or Meridian to St. Luke's in Nampa to instead stay close to home and see non-St. Luke's providers, that could also cost St. Luke's revenue; right?

A. If that's how they responded to the price increase, then, yes.

Q. And if employers decided that because of price increases they were going to try to implement tiers or narrow networks and incentivize employees to stay away from St. Luke's providers, that could also cost St. Luke's revenue; is that right?

A. Only if the providers agreed to participate in the tiering.

Q. Well, if an employer decides to set up its own network and run a network from somewhere, St. Luke's isn't involved in that discussion, is it?

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A. St. Luke's is involved in the negotiation to be in that network. And if St. Luke's tells the person who is organizing the network, "We'll be tier 2 to nobody," then that employer is faced with the same problem they had before tiering. They either have St. Luke's in their best tier or they don't have St. Luke's at all.

Q. Right. Right. But that's going to be up to the employer depending on the finances of a particular -- of a plan; right?

A. And that's the dynamics of negotiation we have been talking about all morning.

Q. By the way, let's just go back to, I think, a comment the court made, which is I think the court asked a question about, you know, whether there is limits on market power.

You keep talking about all these things St. Luke's could do: It could raise prices; it could resist tiers; it could reduce quality; it could stop innovation.

Market power is finite; right?

A. Yes.

Q. Right. So St. Luke's can't be simultaneously increasing price and reducing quality and stopping innovation and resisting tiers? It can't be doing all those things at once?

A. Well, it's going to, in the short run, choose how

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it wishes to exploit its market power, which could be quality, it could be price.

In the long run, as it's doing all this and it becomes entrenched, it can now stop innovating. And through its entrenchment, it's created entry barriers -- which I admit we haven't studied because we haven't looked at the long-run implications of something like entry barriers -- it could then be used to resist innovation as well.

Q. And if healthcare costs go up, then another way that St. Luke's might lose revenue is that some employers might decide to limit or drop coverage; right?

A. I would expected that to be de minimus.

Q. But you haven't studied that to determine the extent to which that might occur?

A. Not in this particular market, but I have considered that as a general issue.

Q. By the way, when we talk about the critical loss threshold, the 8.8 percent, Dr. Argue did explain that when you consider the loss of revenue and associated services, it could be as low as 1.5 percent; right?

A. I think this is the multiplier effect.

Q. I think that's how you referred to it.

A. As I say, if they chose to take the price increase out in primary care and there was a multiplier effect and there was a shift in referrals, that might be what happened.

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But if St. Luke's saw that as a result of their market power, if they decided to take it out in primary care, they would see a shift in referrals, they might instead choose to take it out in hospital services at St. Luke's flagship hospital.

That bottom right-hand cell is up for grabs. And if they have more power, they will get more out of the bottom right-hand cell.

Q. Right. Of course, to the extent that St. Luke's increases its price for other services, those prices -- its prices are going to look even less attractive than its competitors? It doesn't matter where it takes the price increase, it's still got to compete against other hospitals on those services?

A. That's the essence of these negotiations. There is a bottom right-hand cell being negotiated. At any given point in time, there are all these constraints on St. Luke's. You remove one of those constraints, St. Luke's will be better off. The other constraints are still there, but you've removed an important one, and now they're better off.

Q. And when you talked before about patient insensitivity and you gave that example of a $100 physician service, and you talked about how the patient might feel about a 50 percent increase. Do you recall what I'm talking

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about?

A. Not 50 percent --

Q. If there were a 5 percent price increase, you said --

A. It would be a copayment --

THE COURT: Just a moment. We need to not speak over each other. Wait for the question to be completed, and wait for the witness to finish before we start another question.

BY MR. STEIN:

Q. I'm just trying to reorient you, Dr. Dranove, to your testimony to where you gave the example of why patients wouldn't be price sensitive. And you said if it were a $100 and the copayment is "X," a 5 percent increase would only be 50 cents, or something like that.

A. Oh, 50 cents. I'm sorry. I think you said "50 dollars," and you meant "50 cents." And that's where the confusion came.

Q. Now, in that hypothetical, what you're assuming is at least in that hypothetical that the plan doesn't do anything itself; right? That the only thing that changes there from the perspective of the patient is a small increase in its copayment; right?

A. I'm not sure what you have in mind for something the plan might do, so maybe you could give me an example.

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Q. Well, if St. Luke's implements a price increase, the patient may only feel the percentage that corresponds with its copay, but the plan is going to feel the rest of that price increase?

A. That correct.

Q. So the plan isn't going to sit still for the price increase?

A. It's not clear what it could do. After all, it has negotiated the terms of the contract, including the extent to which it can have differential copayments with different providers. That is going to be something in the negotiations with St. Luke's.

Q. That's right. But unless St. Luke's has already obtained the power to increase prices in its contract, it also is not going to have the ability to implement a price increase; correct?

A. Again, if St. Luke's gains bargaining power, each and every one of these tools that has been there to limit St. Luke's power is still there and hasn't changed. St. Luke's will be a more effective negotiator after the deal. Whatever you're saying they could have done to constrain St. Luke's pricing they have already done. They are constraining their pricing now.

Q. And that's why -- I'm sorry. Go ahead.

A. And those constraints get lifted to the extent

3482

that this acquisition enhances their bargaining leverage by reducing alternatives for employees who want to have care in Nampa.

Q. And, of course, that conclusion would be true regardless of whether St. Luke's has market power; right?

A. I -- I think of this in the context of predicting the outcome of this consolidation, and I predict that it will substantially increase their bargaining leverage.

Q. Right. And that would be true regardless of whether St. Luke's has market power?

A. I don't see how you could substantially gain leverage without having market power.

Q. Well, because you said, yourself, Dr. Dranove, that anytime -- that leverage is zero sum. If St. Luke's acquires another provider, they remove an option from the payer; and just by that process, they get more leverage --

A. I think --

Q. -- right?

A. -- during our last conversation, you asked me to define market power, and I talked about acting without constraints. Market power comes when you don't face market constraints.

And we are removing an important market constraint. And since market power is not an either/or -- it's not that you either have it or you don't; it's on a

3483

sliding scale -- this is going to enhance their market power by removing a constraint.

Q. Let's get back to this idea that you like to focus on on the facts on the ground, Dr. Argue.

Again, if we can keep the screen off --

I'm sorry. "Dr. Dranove."

If we can go to slide 17.

Now, I think you acknowledged in your testimony that calculating a critical loss for St. Luke's requires an understanding of how a loss in revenue would affect St. Luke's marginal profitability; right?

A. That's correct.

Q. And so in order to calculate the critical loss, Dr. Argue examined financials for St. Luke's practices; right?

A. Yes, he did.

Q. Those would be facts on the ground?

A. Yes.

Q. You didn't do that; correct?

A. I examined what I thought was the relevant fact, which was the --

Q. Dr. Dranove, I'm sorry. Let me --

A. Yeah, I did look at the facts on the ground.

Q. You did not examine St. Luke's financials; correct?

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A. Because those were not the relevant facts on the ground.

Q. And Dr. Argue -- well, if one were to calculate a variable cost to St. Luke's, are you telling the court it wouldn't be relevant to look at St. Luke's financials?

A. For the physician variable compensation, it would be relevant to look at the professional services agreement because that dictated what the variable costs of St. Luke's would be.

Q. What about for the other services?

A. For the other services, Dr. Argue, I believe, relied on some interviews. And those would not -- the answer for that those were not, I believe, relevant to the proper way of thinking about variable costs. I did not examine any specific documents from St. Luke's to get a better handle on variable costs.

Q. Right. In fact, as you admitted in your report, you didn't do any study of St. Luke's variable costs; right?

A. Other than for the physician variable compensation, that would be correct.

Q. And that's the column that we're looking at in the middle of slide 17?

A. In the middle; correct.

Q. And that's the largest component of the critical loss calculation; is that right?

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A. That's correct.
Q. And the effect of your proposal to increase the physician variable compensation is to increase the critical loss threshold; is that right? In other words, if you increase the variable component of the physician compensation, you are going to increase the critical loss?
A. Not necessarily.
Q. Well, that's the way it works out in your calculation?
A. Because if you increase that component, there will simultaneously be a decision about pricing. Because when variable costs change, which is what would happen under your scenario, your optimal price would change. And so we would have to know what the new price would be in order to determine what the new critical loss would be.
Q. Well, why don't we do it --
THE COURT: Just a moment. When you say "optimal price," what do you mean?
THE WITNESS: The price that they would actually choose to charge under this new regime.
MR. STEIN: Mr. Chase, could you just flip from this slide to the next slide.
BY MR. STEIN:
Q. This shows -- this slide, slide 18, shows the impact of your modified assumptions; correct?

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A. That's correct.
Q. Okay. So now let's go back to slide 17.
Now, the key basis for your assumption that the variable compensation is 95 percent -- which is what you have chosen -- is your understanding that -- what that means, basically, is your understanding is that physicians compensation is virtually entirely variable; right?
A. It's fee-for-service under the current PSA.
Q. Right. And what that means is your understanding is that if physicians bill more RVUs, they will get more pay; and if they get fewer RVUs, they will get less pay?
A. That's correct.
Q. But, In fact, virtually all St. Luke's physicians have a minimum guarantee in their contract; right?
A. That's correct.
Q. Including the Saltzer physicians?
A. Although, I believe it's expected that the Saltzer physicians will exceed that guarantee on average by a substantial amount.
Q. Expected by who?
A. I can't remember the name of the consulting firm that did a study.
Q. Okay.
A. It's in my report.
Q. Well, the minimum guarantee, the existence of a

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minimum guarantee, means that if the physician doesn't produce enough RVUs to exceed the minimum guarantee, St. Luke's still has to pay the minimum guarantee; right?
A. That is correct.
Q. So if the physicians' productivity is below the guarantee amount and a price increase results in a further loss of volume, the guarantee in that case would be a fixed cost, not a variable cost; right?
A. If we were in that scenario. But I don't think that's the relevant scenario for this calculation.
Q. Well, in fact, in order to determine the extent to which -- well, let's back up for a second.
You said you think the Saltzer physicians will exceed the guarantee; right?
A. Again, this is based on a consulting study that I cite in my original -- or my reply report.
Q. Sure. But that's an important assumption for you; right?
A. That is the only analysis that I have seen of whether they are likely to exceed that.
Q. Okay. Well, then would you agree that if they are not likely to exceed the minimum guarantee, that the portion below the guarantee would be fixed and not variable?
A. For those physicians who are below the guarantee, it would be fixed.

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Q. Right. So one of those facts on the ground that Dr. Argue looked at was: Well, let's look at other employed physicians and see what proportion of them are actually exceeding their minimum guarantee. That's exactly what he did; right?
A. Yes.
Q. And that's -- I'm sorry.
A. I'm sorry. But the relevant question is: What would the proportion be for Saltzer physicians?
Q. Well, no, it wouldn't, Dr. Dranove. Because if -- as you testified when you were here last time, if St. Luke's implements a price increase, it's going to be across all of the services or maybe not even physicians services; right?
A. But if the critical loss analysis that Dr. Argue implemented was a critical loss analysis for Saltzer-St. Luke's in Nampa, if we're going to talk about the bottom right-hand cell, then we should talk about the other ways in which they might choose to raise prices, such as raising the prices for their children's hospital, where they face no competition.
Q. Right. But what Dr. Dranove -- I'm sorry -- what Dr. Argue looked at was how are physicians who are being compensated by St. Luke's with a minimum guarantee performing against that guarantee; right?

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A. But that might or might not be --
Q. Am I right that that's what he did?
A. It might or might not be predictive of what would happen with the Saltzer contract --
Q. Am I right that that's what he did?
A. That is what he did, but it might or might not be predictive for Saltzer. And there's an independent study suggesting that something very different may happen at Saltzer --
Q. You keep saying that --
THE COURT: Let's wait until the witness finishes the answer. The court reporter cannot take down two people talking at the same time.
MR. STEIN: I should have taken my lesson from Mr. Schafer from last week.
BY MR. STEIN:
Q. What study are you talking about, Dr. Dranove? Because I'm pretty sure I have never heard of it.
A. It's in my original report in which it states that it's expected that the average Saltzer physician will see a 30 percent -- I believe something like 30 percent pay above the threshold, above the minimum.
Q. By the way, Dr. Argue isn't cherry-picking here; right? He actually calculated, if we look at the third column of slide 17, a higher variability for nurse

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practitioners than the assumption that you made; right?
A. That's correct.
Q. Again, that was based on his analysis or his discussions with St. Luke's personnel?
A. In response to the concerns I raised; correct.
Q. So one of the things you mentioned -- and I'm pretty sure you were careful to couch this in a "I'm not saying it's the case here" type of way -- but you said something to the effect of: Well, even if there are quality standards, the benchmark can be set so low that the doctors don't really have to change their practice; is that right?
A. I have seen that in other markets. That may or may not apply to what they're going to do with their PSA going forward here.
Q. Right. And, in fact, we heard testimony from Dr. Souza of Idaho Pulmonary Associates and Dr. Johnson with Idaho Family Medicine and Dr. Priest with Idaho Cardiology. You are not suggesting that the quality metrics that they have implemented are -- you know, essentially, the bar has been set so low that they're not real, are you?
A. No, I'm not.
Q. Now, one other -- one other item you talked about was this Brookings report. And I think you called it a study, but am I mistaken on that?
A. I think Mr. Herrick called it a study. It's more

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of a policy brief.
Q. Right. And the Brookings report actually strongly supports the types of reforms that St. Luke's is trying to make with regard to, for example, the movement to value-based care; is that right?
A. I think the Brookings report -- I think you actually just called it a study, yourself; it's easy enough. The Brookings brief does review some of the changes that are going on and mentions, for example, that what St. Luke's is doing is one of the changes that's exciting about what's going forward --
Q. Right.
A. -- without mentioning specifically St. Luke's, of course.
Q. Right. But it doesn't just mention it; it strongly -- I mean, that's the whole theme of bending the curve. It's strongly advocating for moving towards those kinds of value-based reimbursement systems; right?
A. That's correct. It wants to find new ways of reimbursing providers.
Q. And the Brookings report doesn't say that alignment of financial incentives can be achieved just as well with looser affiliations as it can with employment or tighter affiliations, does it?
A. I don't think it takes a stand on that.

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Q. And, in fact, the Brookings report, when you look at that section overall on antitrust, it actually advocates that the antitrust authorities be more flexible in evaluating consolidations than they have to date so as to avoid thwarting consolidations that might help take -- help providers take on additional risk; isn't that right?
A. Yeah. I think there are a variety of ways in which providers can consolidate to take on additional risk.
For example, I have done a lot of work over the last few years with on behalf of the American Medical Association talking with physician groups that have been very concerned about how physicians forming group practices are subject to antitrust scrutiny in their efforts to take on risk, and they feel that this is putting them at a disadvantage relative to existing hospital systems that are already in the market.
Q. So if we can go to slide 22, Mr. Chase, of Dr. Dranove's demonstrative.
Your Honor, the screen can go back on for this.
I want to make sure I understand this second bullet point or sub-bullet there. Is it your testimony that Saltzer has the ability as an independent practice to bear financial risk in payor contracts?
A. It's my testimony that other practices around the country comparable in size to Saltzer have chosen to do

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this. I have not done an independent study of Saltzer and whether they can do this separately from simply noting the comparisons.

Q. And are you able to name a single contract that Saltzer had as an independent practice in which it took on risk?

A. I am forgetting whether they have or haven't. I just don't recall.

Q. And you reviewed trial testimony of other witnesses before you testified last time?

A. Yes, I have.

Q. So let me ask you: Nancy Powell, when she testified here in court, at lines *[sic]* 826, line 20 through 827, line 3, there was this exchange:

Question: "When you were at Saltzer, Saltzer only had the goal of entering contracts with gain sharing as opposed to any risk sharing?"

Answer: "Correct."

Question: "And the reason for that is that you believed it was too risky for Saltzer as an independent group of Saltzer's size to be able to take any downside risk; isn't that true?"

Answer: "That would be true."

Did you consider that testimony?

A. So gain-sharing is, in fact, the shared savings

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program that is most prominent under accountable care organizations. I considered that to be risk-sharing. You're sharing in the upside gain but not the potential downside loss.

So I think in the field, that would be considered one type of risk-sharing. Clearly, sharing risk in both directions is another type. And so they have only considered one of those.

Q. So when you refer in your testimony to risk-sharing, you're including in that what could only be upside or gain-sharing?

A. I would consider that to be one of the examples, yes.

Q. Does Saltzer have the ability as an independent practice to do downside risk-sharing?

A. Again, I have not done a study of Saltzer in particular, but there are other practices that are pursuing that.

Q. Who?

A. I don't recall specific names.

Q. So another topic that you talked a fair bit about in your testimony is ACOs. I take it the court should understand from your testimony that you're a big believer that ACOs are going to change the way care is provided in a positive way?

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A. I wish I was a big believer. I think we talked last time about how in general I have grown skeptical of some of these new organizational forums. I have seen over the last 20 years too many promising efforts fail. And so I'm optimistic because, by nature, I'm an optimist. But I wouldn't put my money on it.

Q. In fact, you're not convinced at all that ACOs are going to turn out to be beneficial; right?

A. I'm personally not convinced yet. I think the jury is out. And as an empiricist, I think, you know, one holds to the null hypothesis that's kind of -- as a statistician, one tends to be like somebody from Missouri. You've got to show me before it actually -- before I actually believe it.

Q. Did you see any evidence in the record that Saltzer as an independent practice was consider forming its own ACO?

A. No, I did not.

Q. In fact, not even Saint Al's, with resources that it has, has formed an ACO; is that right?

A. That's correct.

Q. And are you telling the court that an unwound Saltzer is likely to spearhead an ACO when it wasn't even considering doing so before?

A. I believe that in many parts of the country -- in

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fact, I think despite the fact that we have hundreds -- I think it's now hundreds of physician groups around the country forming ACOs, the vast majority of physician groups are taking a wait-and-see attitude. And Saltzer may be one of those taking a wait-and-see attitude; I don't know.

But I would speculate that if ACOs organized by physicians do prove concept, groups like Saltzer will at least pay attention and decide whether this is good for them. But I'm not going to predict whether they are going to form one or not.

Q. And did I understand you said that proof of concept for ACOs could take five to ten years?

A. I think there were an original set of ACO studies that were done under the auspices of the Center for Medicare Services, which started back in -- I want to say the mid 2000s, maybe the late 2000s. It took several years for the results, and those are disappointing.

So there are a lot of people gambling that this is going to be successful. But, yeah, it may be quite a few years before we learn what works and what doesn't. And if some firms become entrenched during that time and it turns out they don't work, Brookings has warned us that that could lead to long-term consequences 10, 20 years down the road.

Q. Okay. So let's make sure we understand this, Dr. Dranove. You're not convinced that ACOs are even going

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to have any benefits, but if they ultimately do have benefits at some point in the future and if those are demonstrated and if Saltzer is unwound, that they might take a look at that and then might form an ACO. Do I have that right?

A. They might form an -- if Saltzer was unwound, they might form an ACO tomorrow. I don't know if and when they're going to do it. I don't know if ACOs will work, but I do know that an entrenched St. Luke's is going to exert market power whether ACOs are successful or not.

Q. Dr. Dranove, in the scenario I just described to you, did I misstate any of your positions?

A. State it again, please.

Q. Sure. You're not convinced that ACOs are going to have any benefit at all?

A. Correct.

Q. The benefits haven't been shown?

A. Mm-hmm.

THE COURT: You need to answer audibly, yes or no.

THE WITNESS: Yes.

BY MR. STEIN:

Q. If they are shown at some point in the future, Saltzer might observe those benefits and then decide to form its own ACO?

A. Or they may decide to form an ACO before the

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benefits have been shown. So I agree with you, but I think there are other possibilities.

Q. And as you said, your opinion that they may decide to do so, that's just speculative; you haven't seen any evidence that they were considering it?

A. It's based on my watching what's happening with physician groups around the country and understanding that many physician groups are on the fence about this.

Q. And one last thing, Dr. Dranove. When we talk about your theory and how St. Luke's -- why you say allowing St. Luke's to go forward with this transaction might be a bad thing, you say one of the things that might happen is it will give St. Luke's the ability to resist innovation; is that right?

A. That's correct.

Q. Let me just ask: From your perspective, as somebody who presumably has at least -- I know you haven't been here -- but read the testimony of Dr. Pate, Pat Richards, Jim Souza, Marshall Priest, Mark Johnson, Bayo Crownson, and all the people who came through this courtroom and talked about what St. Luke's is doing, is it your opinion that what St. Luke's is trying to do is resist innovation in healthcare for consumers in Idaho?

A. Having read that testimony, I can say that I have read similar comments by providers in integrated systems

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over the past two decades in which the performance didn't measure up to the words, providers that were sometimes actually at the same time pursuing other objectives, such as market power.

So I don't put a lot of stock in the perhaps very sincere statements of some of the people on the ground, the physicians who are trying to develop care, in what the future direction of the organization will be.

MR. STEIN: I don't have any further questions, Your Honor.

THE COURT: Mr. Herrick.

MR. HERRICK: Very briefly, Your Honor. I guess I shouldn't make promises that I can't keep. I don't know how long this is going to take.

REDIRECT EXAMINATION

BY MR. HERRICK:

Q. Professor, Mr. Stein asked you about BCI's negotiations, recent negotiations with St. Luke's. I want to ask you just as a general question, as a general principle: How relevant would you consider contract negotiations that are ongoing while one of the parties is in litigation?

A. I would be very hesitant to draw conclusions from that. Certainly, if they had power, they would be less likely to try to exploit it under the eye of the court.

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Q. And Mr. Stein also mentioned the term "consolidations." I believe that was the term Mr. Stein used with respect to the Brookings brief, not study.

Do you recall whether the Brookings brief distinguishes between mergers and looser forms of integration through contractual provisions, for example?

A. They identified both as alternatives for achieving -- bending the cost curve or the Triple Aim.

Q. And ultimately, what did the Brookings group conclude for mergers like the acquisition in this case?

A. Even noting some of the positive studies, such as the Shortell work, on the types of mergers that St. Luke's is an exemplar of -- an example of, excuse me -- they suggest we tread carefully, that we worry about the fact that the jury is still out and that they are difficult to unwind, and they'd like to see more encouragement of looser affiliations.

Q. One last question, Professor. In your experience and study across the country of what's going on in healthcare, is it your opinion that independent groups of Saltzer's size can participate and do participate in risk-based arrangements without forming a Medicare ACO?

A. I'm sorry. Without?

Q. Without forming a Medicare ACO.

A. Yes. There have been -- you know, the health

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maintenance organization movement, for example, was all about groups, sometimes very small, participating in risk-sharing arrangements.

My colleague, Joel Shalowitz, who teaches in my department, the health management department that I direct at Kellogg -- he actually owns several physician group practices on Chicago's North Shore with a total of, I think, 20 to 30 primary care physicians total, and they have been engaged in risk contracting since when Joel's father ran these practices several decades ago.

MR. HERRICK: Thank you, Professor. I have no further questions.

THE COURT: Mr. Stein.

MR. STEIN: No further questions, Your Honor.

THE COURT: All right.

EXAMINATION

BY THE COURT:

Q. Dr. Dranove, I am assuming that everything you've said applies without regard to whether it's a for-profit or not-for-profit institution; is that correct? Does that change the dynamic at all?

A. There has been long literature on whether nonprofit medical providers behave differently from for-profit medical providers. I have contributed to that literature.

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There are some who are perhaps a little more extreme than I am but actually may be more part of mainstream in economics that say that nonprofits are just for-profits in disguise. It's a cynical term, I agree.

Q. Okay. My apologies to St. Luke's and Saint Al's for --

A. And as with any statistical research, there is variation around the mean.

Q. All right. I want to make sure that I -- I got a little lost in which side you were taking and which side was necessary to your analysis in terms of whether the -- what the impact would be if the compensation for physicians was a fixed or variable cost. I kind of got lost.

A. Sure.

Q. Now, as I understand it, that if the variable costs are greater -- I mean, you either have variable or fixed, one or the other; right?

A. Right.

Q. So if the variable costs are greater, then it would seem to me that the -- that the critical loss would have -- would be a higher percent --

A. Go up; correct.

Q. -- would go up to be able to cover the same percentage of a price increase?

A. The thing is when you compute critical loss, you

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have to account for price and variable costs.

Q. Right.

A. And if they were to change their compensation so as to change the variable costs percentage, economics will tell us that if you change the variable costs percentage, you're likely to also change price.

So I would have to know what the new price would be -- this is kind of a but-for world. So now they are changing one thing, they are changing the compensation to physicians. In that but-for world, variable cost changes and price changes, I need to know both before I can compute the new critical loss threshold.

Q. I guess I was thinking of variable costs as simply being a -- that if a patient does not come in the door under a fee-for-service, the doctor does not get compensated; right?

A. Right. So variable costs would fall.

Q. All right. If they're going to be paid anyway, then if revenue drops, i.e., patients don't come in the door, then -- and the -- and the compensation has been fixed, then it struck me that you would need to have a smaller percent of lost revenues, lost patients, in order to compensate for -- to compensate for increased prices?

A. Only if St. Luke's, at the time it changed its compensation agreement, kept its price to change. But a

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classic result in microeconomics is that if your variable costs fall, it will be in your interest to lower your price because each additional unit doesn't cost you as much to sell so you want to try to sell more units.

If St. Luke's follows that economic rule, when they move to the new contract that lowers the variable costs, they might actually lower their price as a result.

Now, mind you, market power will allow them to have a higher -- the lower the price, but compared to what it would be without having market power, it would still be higher.

THE COURT: Counsel, do you have any questions in light of mine?

MR. STEIN: I just want to clarify.

RECROSS-EXAMINATION

BY MR. STEIN:

Q. Dr. Dranove, you had an important qualifier there, which was that St. Luke's may change -- may change the compensation when it goes to readjust the compensation; right?

A. That's correct. I think you meant may change their price when they readjust the compensation.

Q. Right. But there is no readjustment of the compensation, even under the Saltzer contract, for five years; right?

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A. Which means that the variable costs will be very high. It will be that high percentage for five years because it's -- depending on whether you think they're going to exceed that minimum threshold.

Q. Right, depending on whether they exceed the threshold.

A. Understood.

MR. STEIN: That's all I have, Your Honor.

MR. HERRICK: No further questions, Your Honor.

THE COURT: Thank you, Mr. Herrick.

You may step down. Thank you.

MR. HERRICK: Your Honor, just one very brief housekeeping matter.

THE COURT: Yes.

MR. HERRICK: Professor Dranove testified about two additional exhibits from his report, so we would like to move those into evidence.

THE COURT: Those are?

MR. HERRICK: The numbers are 1800, which is Figure 29 from Professor Dranove's opening report.

THE COURT: Is there any objection, Mr. Stein?

MR. STEIN: Your Honor, let me just find it really quickly and I can tell you.

MR. HERRICK: It's Figure 29.

MR. STEIN: No objection.

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THE COURT: All right.

MR. HERRICK: The other one is 1814, which is reply report Figure 1.

THE COURT: Any objection?

MR. HERRICK: I'm putting Mr. Stein on the spot here.

MR. STEIN: No objection.

THE COURT: All right. 10 -- 1814 and 1800 will be admitted.

(Plaintiffs' Exhibit Nos. 1800 and 1814 admitted.)

MR. HERRICK: Thank you, Your Honor.

THE COURT: Call your next witness.

MR. WILSON: Your Honor, at this time we call Dr. Kenneth Kizer.

THE COURT: Dr. Kizer.

KENNETH W. KIZER,

having been first duly sworn to tell the whole truth, testified as follows:

MR. GREENE: Your Honor, we have a binder for Dr. Kizer in the event he needs to refer to some of his materials. We also have, I believe, a clean copy of the doctor's expert reports if Your Honor wants something to refer to.

THE COURT: That would be helpful if you have that.

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THE CLERK: Please state your name and spell your name for the record.

THE WITNESS: My name is Kenneth W. Kizer. Last name is spelled K-I-Z-E-R.

THE COURT: You may inquire.

MR. GREENE: Thank you, Your Honor.

DIRECT EXAMINATION

BY MR. GREENE:

Q. Good morning, Dr. Kizer.

A. Good morning.

Q. On the screen is Demonstrative Exhibit 3131. Do you recognize this slide deck, Doctor?

A. I do.

Q. And was this prepared to illuminate and illustrate your testimony today?

A. It was.

Q. Turning to the next slide.

Excuse us, Your Honor. It'll just take a moment for this to warm up.

Turning to your qualifications, Doctor, what was your major at Stanford?

A. Biological sciences.

Q. What was the focus of your MPH program?

A. My master's degree is in epidemiology.

Q. And you took your medical training at UCLA?

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A. That is correct.

Q. You are, in fact, a licensed physician?

A. I am licensed in the state of California.

Q. Okay. And you are a distinguished professor of medicine in nursing at the University of California at Davis?

A. That is correct.

Q. And what is the Institute for Population Health Improvement that you're the director of?

A. When I was recruited to return to academia at the University of California Davis, I was asked to establish this new institute that focuses on population health.

Q. So just for a layperson like myself, what's the difference between population health and an individual patient's health?

A. Population health refers to the health status or health outcomes of a group of individuals, a population. That population may be defined by geography or age or race or ethnicity or political jurisdiction, any number of ways that populations can be defined.

And the population health refers to the net health outcomes that are a result of healthcare, public health interventions, as well as that category of things known as the social environmental determinants of health, such as education and housing and other things that often have a

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substantial impact on the health of a population.
Q. And can you give us and the court an example of a population health-based health measure?
A. There are many measures, but a specific example might be the mortality rate or infant mortality rate or any number of measures that look at the health of a group of individuals.
Q. And what is your role as chief quality consultant for the Medi-Cal program?
A. Under the Institution for Population Health Improvement, we run a number of different programs. One of them is known as the Medi-Cal Quality Improvement Program for the state of California in which we're trying to improve the quality of care for Medi-Cal beneficiaries, Medi-Cal being the state Medicaid program.
Q. Can you give us an example or two of the kinds of programs you're running through that role?
A. I'm not sure I understand your question. But the -- in the Medi-Cal quality improvement program, we're working with the department to analyze Medi-Cal beneficiaries to see where there are opportunities to improve care.
We have worked with them to develop a quality plan or quality strategy for the program. We have done an inventory of what they're currently doing and identified

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opportunities to do more in that regard in the future.
Q. Okay. And what is the California Health eQuality Program?
A. The California Health eQuality Program -- or "CHeQ," as we call it -- is another program that we manage for the state of California. And this is the program to develop health information exchange technology throughout California - --
Q. And what is a health information exchange, Doctor?
A. -- health information exchange is another category of health information technology that is being widely implemented and deployed today. Perhaps the one way of thinking about it is health information exchange does in a community what an electronic health record does within a hospital. So that health information exchange connects the different hospitals and medical groups and clinics in a community, a city, a state, so that they can share information between and amongst them like what an electronic health record may do within a hospital.
Q. So what kinds of information would be exchanged under -- exchanged by way of a health information exchange? What kind of clinical information might be exchanged?
A. Well, the goal -- I mean, health information exchange is like electronic health records. And this whole area of health information technology is that it's moving

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forward. By 2016 or 2017, the federal government's plan is that one will be able to exchange comprehensive health information through HIE.
Right now, depending on in different states and different communities, there are varying amounts of information that might be exchanged -- that might be laboratory data, clinical notes, imaging data -- you know, a variety of things, information that's relevant to provide patient care.
Q. And the California Health eQuality Program, is that analogous to the Idaho Health Data Exchange, Doctor?
A. It's analogous in that both are funded by the Office of the National Coordinator and the U.S. Department of Health and Human Services, and we are moving towards the same end point. You know, Idaho has -- the intent is to have one statewide exchange.
In California, we currently have 25 exchanges operating and about another 10 on the drawing boards to be rolled out. And that is just a reflection of the larger size and complexity of the state.
Q. Thank you, Doctor. Let's turn to the next slide.
Are you board-certified in any medical specialties, Doctor?
A. I'm board-certified in a number of specialties and subspecialties.

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Q. What are examples of the professional societies you have been elected to?
A. I'm a fellow of a number of the professional societies I belong to, such as the American College of Emergency Physicians, the American College of Medical Toxicology, the American College of Physician Executives, and a number of others.
Q. Okay. I noticed, sir, that you have also been elected to the Institute of Medicine and the Academy of Public Administration. Is it a unique honor to be elected to both, and if so, why?
A. Being elected to the National Academy of Sciences or the National Academy of Public Administration is considered one of the highest accolades or recognitions of one's professional achievement. It's unusual to be elected to both since they cover quite different areas of expertise.
And when I was elected to the National Academy of Public Administration, I was told that I was one of about a dozen such people historically that had been elected to both.
Q. Let's turn to your -- some of your selected former positions, which may explain why you were elected to the Academy of Public Administration. Were you the Undersecretary for Health in the U.S. Department of Veterans Affairs?

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A. Yes. President Clinton had asked me to assume that role, and I served as the chief executive officer for the Veterans Affairs healthcare system from 1994 through 1999.

Q. How large is the VA system?

A. Last year, the VA had about 8.3 million enrollees, a budget of -- a medical care budget in excess of 50 billion, and about 275,000 employees. It's a very large -- I mean, it's the largest healthcare system in the United States.

Q. And what are you proudest of doing while CEO of the VA healthcare system?

A. I mean, quite simply, I am proud that the care provided by the VA is markedly better today than it was when I took over. And the transformation of the VA that I engineered and led is widely acknowledged as one of the, if not the, largest and most successful healthcare turnarounds in U.S. history.

Q. Can you at a high level and briefly describe the nature of that transformation?

A. It was basically a quality improvement project. The intent was to improve the quality of care provided to veterans, to reduce the cost, and to increase the satisfaction and responsiveness to patient needs of the system.

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Q. Okay. Has your work at the VA been the subject of various case studies at schools of management?

A. The transformation of the VA has been the subject of dozens and dozens of reports in the peer literature. It's been the subject of multiple doctoral and other dissertations, some books. It's also used as a case study by Harvard Business School as a case study in radical organizational changes. It's used by Yale School of Management, used by other entities as an example of organizational transformation.

Q. In your role at the VA, were you the highest-ranking physician in the federal government?

A. That is true.

Q. Higher than the Surgeon General?

A. Yes. That's correct.

Q. Okay. What was your role as director of the California Department of Health Services?

A. In brief, my -- I was the top health official for the state of California through most of the 1980s.

Q. And was part of your role to provide healthcare services to individuals in California?

A. During my tenure in that role, we were responsible for a number of programmatic areas, including all the public health programs, also all of the publicly financed health insurance programs, such as Medicaid.

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We were also responsible for the licensing and certification of all healthcare facilities, all -- many thousands of them, as well as for running the environmental remediation programs.

Q. And with respect to that portion of the department that dealt with publicly funded healthcare, approximately how many enrollees were in those programs at the time?

A. At that time, as I recall, there were in excess of 5 million enrollees in Medi-Cal. I am a bit more familiar with the current number since I work with that program regularly. And currently Medi-Cal covers about 8-and-a-half million individuals in California. More than half of all children in the state are covered in by Medi-Cal as their health insurer. And under the Affordable Care Act, that enrollment will probably increase by somewhere between 1 -- 1-and-a-half and 2 million individuals over the next two years.

Q. And what were your years of service as director at the Department of Healthcare -- Department of Health?

A. 1984 through 1991.

Q. What was your role with respect to the introduction of managed care into the Medi-Cal system?

A. Again, the -- it was both mine and the administration's feeling that we could do a better job in providing quality care and more efficient care through the

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use of managed care programs.

And so we, in essence, pioneered the introduction of managed care into Medicaid, which while California has long been a leader in managed care in the commercial sector, had not been penetrated into publicly financed programs.

Q. And on the provider side, did this involve risk-based contracting with providers?

A. Well, there were multiple different models that were being -- again, we were pioneering, so we were trying different models. But the contracting entity was at risk for -- they were at-risk contracts, yes.

Q. Okay. And when you left your position as director, roughly what percentage of Medi-Cal enrollees were being served under risk-based contracts?

A. Through the best of my recollection, it was probably around 25 percent or so of beneficiaries -- 20, 25 percent, something like that.

Q. So that would be several million people; is that correct?

A. Probably a million, million-and-a-half, something like that at the time. I haven't thought about those numbers in a long time.

Q. Okay. Fair point.

Moving on to your additional current and former positions, you are the founding president and CEO of

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something called the National Quality Forum; is that correct?

A. I was the founding president and CEO of the National Quality Forum.

Q. And what does the -- may I call that the NQF? Is that appropriate nomenclature?

A. NQF works.

Q. What does the NQF do?

A. The NQF is the -- it's technically a voluntary consensus standard-setting body that endorses quality of care and other performance measures for the healthcare industry. These measures are widely used by public programs, such as Medicare and Medicaid, as well as widely used by commercial insurers and other payors.

Q. So what is an example of an evidence-based quality standard issued by NQF?

A. Again, recognizing that there are hundreds of such measures today, one example that perhaps many people are familiar with is the hemoglobin A1c measure. Hemoglobin A1c is a blood test that is used to measure or determine how well a diabetic is under control, and it is one of a number of measures that have been endorsed for looking at the quality of care for individuals with diabetes.

Q. Okay. Now, how has that standard been used in either public or private settings?

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A. It's a widely used standard throughout American healthcare today by payors of all types. And, you know, it's important to -- one of the reasons why the NQF was so important and why standardization of measures are so important is that you can call something the same measure, but if you don't calculate the numerator and the denominator or however the measure is being calculated exactly the same way, you can't make apples-to-apples-type comparisons.

So having standardized medicine -- or measures that are used across healthcare allows one to make valid comparisons of the quality of care from one health plan or one provider to another.

Q. And what is Medsphere, Doctor?

A. Medsphere is a private company that provides open-source electronic health records.

Q. So you actually sell EMRs to the healthcare industry?

A. That is correct.

Q. Okay. And do Medsphere products interoperate with other EMRs?

A. Well, when one places an electronic health record in a hospital or health system, it would be a rare exception when you don't have to interface with some other preexisting record of some type. In some cases, it may be simply a payment or billing system. In others, it might be, you

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know, the hospital decides they want to keep their laboratory system but change everything else, or they keep their radiology or imaging system.

And so creating interfaces is a normal and routine part of implementing electronic health records in most hospitals and health systems.

Q. And does Medsphere provide the wherewithal to allow for those -- the creation of such interfaces?

A. It's an integral part of implementing an electronic health record.

Q. So Medsphere itself has staff that would be able to assist and actually complete interfaces and allow for interoperability?

A. Yeah. I mean, Medsphere both has its own staff but also works with what are known as integrators or system integrators, of which there are many companies that integrate systems. And so it does both depending on who the customer is.

Q. Okay. Turning to the next slide, Doctor. Approximately how many studies, book chapters, and reports have you written over your career?

A. Over the last 30-plus years, I have authored or coauthored in excess of 400 journal articles, book chapters, standalone reports, monographs, other items for the professional literature.

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Q. And before the court is essentially a sample of some of your most recent work; is that correct?

A. These were a few of the things that have been produced in recent years.

Q. I am intrigued by the middle one, I must say, Doctor. What prompted you to ask the question of "What is a world-class medical facility?"

A. That was a very interesting project in that the -- when the Walter Reed Army Medical Center was put on the base closure and the Congress decided to build a new National Walter Reed Medical Center, it was put in legislation that it would be built and constructed and designed to be a world-class facility. It was -- work had progressed. There was concern that it wasn't. So Congress mandated that an independent committee be established to review the work and see if that facility as well as another hospital, new hospital, that was being constructed were, in fact, being designed and constructed to be world-class facilities.

We -- I chaired the commission -- the commission that did that review. As part of the work, there was no standards for what is a world-class medical facility that had been developed at that time. We looked at all the other available standards, found that they couldn't be directly applied. So we created a new set of standards, which were

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subsequently adopted by the Department of Defense as well as codified in federal law by the Congress in 2010 and also resulted in excess of $800 million additionally being appropriated for the construction of the new National -- or Walter Reed National Military Medical Center.

Q. Thank you, Doctor.

Turning to the "Extreme Makeover" article, just very briefly, what's that about?

A. I was asked to basically detail in journal format what happened to transform the Veterans Affairs healthcare system. So it's a review article of the basic strategies and tactics that were used to transform the VA.

Q. Okay. Turning to the next slide, Doctor, does this summarize the points you understand defendants have made about the relationship between the employment of physicians, specifically the employment of Saltzer physicians, and improvement of care?

A. This slide attempts to summarize in brief form what the defendants' position is as far as stating that employment is necessary to achieve the greatest benefits of integrated care, that there is a necessary core of primary care providers that's necessary, that it's necessary that everyone be on the same electronic health record and data analytics tool, and that employment is necessary to align physicians to provide higher-quality, lower-cost care.

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Q. And did you reach a series of conclusions about these assertions?

A. I did.

Q. And looking at the slide before you, what was the first and perhaps overarching point that you make?

A. I think the primary point is that the employment of physicians -- i.e., the transaction of St. Luke's acquiring Saltzer -- is simply not necessary to provide integrated patient care.

Q. And with respect to the core assertion, what was your conclusion?

A. Well, the core theory that has been espoused by Professor Enthoven is just that; it's a theory that is not supported by empirical data.

Q. Okay. And what was your conclusion with respect to the assertions with respect to health IT capacity?

A. You know, health IT has lots of tools available today, and independent providers certainly have available to them a variety of electronic medical records or data analytic tools that can be used to support or facilitate providing integrated patient care.

Q. And finally, Doctor, with respect to a transition to nonfee-for-service payment structures, what did you conclude?

A. Again, I don't find that employment is necessary

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nor sufficient to move away from fee-for-service such that the incentives are more aligned for providing higher-quality, lower-cost care.

Q. Turning to the next slide, Doctor. Is somehow Luke's unique in its effort to improve quality and lower cost in the United States?

A. Well, you know, in brief, there is nothing special that St. Luke's is doing that isn't being done elsewhere throughout the country. You know, we are in the midst of a -- of a major sea change in healthcare. You know, it would not be inaccurate to say that we are in a revolution in healthcare for very good reason. You know, we spend too much; quality is not good enough; the system doesn't respond to patients. There are many reasons why this is necessary. But the -- what St. Luke's has aspired to or asserted that it aspires to is the same thing that's being done in communities and states across the nation.

Q. Okay. With more specificity, what is -- what is the Triple Aim, Doctor?

A. The Triple Aim is a way, simply, of how do we communicate what it is that needs to be done. We want to improve quality. We want to lower costs. And we want better health outcomes for our communities to improve population health.

Q. Were you involved in the development of what

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became the Triple Aim?

A. Yeah. During my tenure at the National Quality Forum, I was involved in many of the conversations with Dr. Don Berwick, who was then at the Institute for Healthcare Improvement, in formulating some of these ideas and how this might be communicated.

Q. Have attitudes in physicians changed in recent years with respect to the goals of the Triple Aim?

A. I think that, again, it would be safe to say that there has been a substantive shift in physician attitudes in this regard.

Indeed, I was -- a couple of weeks ago in an article in the *Journal of American Medical Association*, it was reported that 95 percent of physicians now understand and recognize they have a responsibility for lowering the cost of healthcare.

And that type of finding, you know, ten years ago would have been pretty unthinkable.

Q. Okay. Given this, what you described as a revolution in healthcare, is there a consensus that one needs to employ doctors to achieve the Triple Aim?

A. No, there is not.

Q. Let's turn to some of the specific assertions, Doctor, that have been made in support of this transaction. This slide -- does this slide capture your specific

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conclusions with respect to the necessity of employing Saltzer physicians to -- is better than other affiliation models?

A. The claim that employment yields greater benefit than other affiliation models is simply not supported by the empirical or experiential evidence. Employment has not been shown to be a superior organizational structure.

And I think what really has emerged out of the literature in recent years is that there are a number of key organizational functionalities that are what are important to integrating patient care, not the organizational structure or form of that.

Q. Okay. Your slide describes Saltzer -- the St. Luke's assertion as a fallacy. Is that -- is that your perspective? Is this a kind of fallacy?

A. You know, I think it's a fundamental flaw in the reasoning of where they have been going.

Q. Okay. Turning to the next slide, there are various assertions here. Firstly, looking at the third bullet, how does your experience as CEO with the VA healthcare system inform your opinion about these claims?

A. Well, I think the VA provides, as does the military healthcare system, very relevant experiential information.

When I went to the VA in 1994, it was a fully

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financially integrated healthcare system that was providing very fragmented care. Five years later when I left, nothing had changed with regard to the employment relationship with physicians, but it was providing much more integrated care because of a number of changes we had made in how the organization approached its work.

Q. So would it be fair to say that at least in the context of the VA, employment did not guarantee a clinical outcome?

A. No. I think the facts speak for themselves that in all the physicians were employed before, and it was providing in the aggregate less than ideal quality of care, costs were increasing rapidly, and care was highly fragmented.

Q. Okay. Now, looking at the first bullet on that slide, what do you mean that, quote, "Full financial integration is not synonymous with effective clinical integration"?

A. I think one of the traps, perhaps, that one can fall into in thinking about these issues is equating an integrated delivery system with integrated patient care. The goal and what we are trying to achieve is integrated patient care.

That -- having a fully financially integrated delivery system such as the VA in the early 1990s, certainly

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did not in that case, or even today with many of the military treatment facilities, result in integrated patient care. And you simply cannot equate integrated delivery system with integrated patient care.

Q. But, Doctor, doesn't it -- doesn't it just kind of make common sense that a tighter employment relationship would be better if you want to integrate care?

A. Well, as anyone who has worked with physicians knows, just because they're employed doesn't mean that they're necessarily going to be on the same page as the organization.

So I do not think that -- certainly my experience, and I think many others would attest to the fact, that employment does not link with providing more integrated care.

Q. Now, Professor Enthoven in his testimony in this court argued that doctors cannot serve two masters. What do you think about that concept?

A. Well, I'm not -- it's a little bit confusing because doctors really only have one master, and that's the patient. So in all of these conversations, the patient is the master who doctors serve.

As far as whether they have a -- an employment or organizational relationship, again, perhaps the VA provides -- could be instructive insofar as about a third of

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the physicians who work for the VA are employed part-time by the VA and are employed elsewise, typically with academic health centers or universities; so that they have an ongoing employment relation with two entities. And that -- I mean, it's not an issue.

So I'm not sure what the -- the basis for Professor Enthoven's assertion in that regard is.

Q. Okay. Now, with respect to your second bullet, why is the lack of a standardized definition of what constitutes an integrated delivery system important to your thinking?

A. Well, in some ways, it's kind of like the question with the National Quality Forum and why do we -- when we have performance measures, do we have to define them exactly the same way.

In this case, there are many different models and governance structures that qualify as integrated delivery systems. So that when people talk about integrated delivery systems provide more integrated care, it's not clear what they're talking about because there is many different flavors, if you will, of what is an integrated delivery system.

Q. Okay. Actually, apropos of that point, let me take you to the next slide. What is this slide telling us?

A. This slide just highlights for illustration

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purposes some of the different models of integrated systems. This is a document that was put forth by the American Hospital Association in recent years.

Q. So does this slide represent a spectrum of structural approaches to clinical integration?

A. Yeah. I mean, what's highlighted in the five columns that are shown here is a spectrum, a sample. There are additional models that could be included as well. For example, the most highly integrated, most fully financially integrated system in the country, the VA or the military, is not depicted on the slide.

Q. So where would the VA and the military system fall on this slide if it could be widened?

A. Well, as far as their degree of financial integration, they would be -- I guess, depending on one's orientation, left or right, it would be to the other side of Kaiser Permanente or Cleveland Clinic.

Q. Now, starting at the other side of the slide, what is -- what is a bundled payment?

A. Bundled payments for episodes of care is one of the models that's currently being pursued by the federal government as a form of integrated delivery.

And basically, the model there is that you take an episode of care, which might be something like a -- having a coronary artery bypass surgery, and all of the care that is

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required for that surgery starting from the presurgical evaluation to the surgery, the in-hospital care, the care provided after the individual goes home and the rehabilitation -- it would all be included in the bundle, and one would get a set payment for that. And the provider, if you will, is at risk of a -- you know, providing all the services and meeting the associated quality metrics for the price associated with that.

Q. So how does that militate in favor of integrated care?

A. Well, it requires all of the providers to work together to the common goal of optimizing the outcome for the patient.

Q. And are these payment systems being used today?

A. They are being used today, both by Medicare and it's part of the Affordable Care Act. They are doing more in that regard. There are also be used by private payors.

Q. And would these kind of structures be used both for employed physicians and independent physicians?

A. Well, the -- the bundled payment, per se, is agnostic to whether they are employed or independent physicians. It's up to the entity that is contracting to provide that care as to how they provide it. And it's being done with, you know, both models.

Q. In the middle of the continuum suggested by this

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slide is something called a PHO. What is a PHO?

A. PHO is the abbreviation for physician hospital organization.

Q. And what is that?

A. It's basically where physicians align with hospitals and may align with them either in an employment or nonemployment relationship.

Q. And in a PHO model, could the PHO pay independent physicians based on quality metrics?

A. Well, in that model, that would be rather typical, is that they would be paid for their performance.

Q. And in the slide Advocate is mentioned as an example of this. Do you have any knowledge of what Advocate does?

A. Advocate is a large PHO in Illinois that has achieved attention for its success in incorporating both independent physicians and a smaller number of employed physicians in their PHO model to improve quality of care.

Q. Okay. And next over is Geisinger and Intermountain, which are both described as having a mix of employed and independent physicians. Is that your understanding of those two systems?

A. That's correct.

Q. And I take it you have some greater knowledge of Intermountain based on your teaching; is that correct?

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A. For the past --

MR. KEITH: Objection, Your Honor. I don't believe this testimony is in any of his reports as to Intermountain.

MR. GREENE: He has spoken in his report about alternate models. I think it goes to that. We also have testimony in the record from Ms. Richards that they do employ both some physicians and they also have significant independent physicians.

THE COURT: Mr. Keith.

MR. KEITH: There are certainly examples in the reports of systems that Dr. Kizer believes would be alternatives to the existing deal. Intermountain Healthcare is not one of them.

THE COURT: I'll sustain the objection.

MR. GREENE: Thank you, Your Honor.

BY MR. GREENE:

Q. Going further to the right is Kaiser. And did Kaiser start with employed physicians?

A. It did.

Q. And why was that the case?

A. Well, Kaiser, albeit it had a different name at that time, was founded in the height of the Great Depression in 1933 and was originally established as an industrial medical clinic. The original work was done with one of the

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Colorado River Aqueduct project in Southern California, and later it was used in the Grand Coulee Dam with the Kaiser shipyards. And again, for many years, Kaiser was a -- only provided services to occupational workers at these large projects.

And the way -- again, going back to its origins in the Depression, the way that they were able to finance care was to charge a -- basically a monthly or daily premium per worker, 5 cents a day, for providing care, and then they employed physicians to provide those services.

Q. And in the modern parlance of healthcare, what sort of a model is Kaiser?

A. It's -- I'm not sure -- quite sure what you're asking.

Q. Are they -- if one were to spool ahead to the current day, aren't they a health maintenance organization?

A. They are often held out as kind of the penultimate health maintenance organization.

Q. And has that model been popular across the United States?

A. Kaiser has its main presence, for historical and other reasons, in California with -- and they have hospitals in California, Oregon, and Hawaii. They have clinical or outpatient facilities and a presence in about a half a dozen other states.

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Their model has not been successful everywhere. They have tried in Texas and North Carolina and New England states and abandoned those markets.

Q. Professor Enthoven spoke frequently about Kaiser. Is St. Luke's Kaiser of Idaho?

A. I don't see the comparison.

Q. Okay. Fair point.

Where on this chart would clinically integrated physician groups not affiliated with a hospital land?

A. Well, they could fit in probably a couple of categories. Again, the -- this looks at the -- the headings there are for the type of clinical integration. In, say, an IPA, an independent practice association, physicians could fall under a bundled payment or bundled payment for chronic care management.

Q. And do such structures relate pay to quality performance?

A. They do.

Q. In summary, Doctor, is it your opinion that there are various ways to achieve quality of care?

A. Well, there are many ways of achieving quality of care, and there is many organizational structures that can be utilized to improve quality of care. And this is a rapidly evolving area.

As the new healthcare economy and the payment

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mechanisms change, we're seeing a tremendous amount of activity across the country in how physicians and physicians and hospitals and all of the different types of providers are coming together to improve quality and reduce costs and provide better health outcomes.

Q. And is that reflected in the literature with respect to these issues?

A. I mean, it's hard to pick up any journal today and not find at least one, if not multiple, articles relating to these general issues. I mean, it's a topic of intense interest throughout the sector.

Q. Okay. So looking at this slide, what is this slide telling us, Doctor?

A. Again, this slide was intended just to show a sample of the literature that makes clear that there is no standard definition; that integrated delivery systems come in lots of different sizes and shapes; and that while they have generally been associated with providing higher quality, less so with lower cost -- but while that has been perhaps a relatively consistent theme throughout the literature, the types of organizational structures that have been used to do that are all over the board.

Q. And looking at the McWilliams study, what was the conclusion there?

A. I think there were perhaps two important

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conclusions from that recently published study -- I think it was just published in June of this year -- was that physician groups, independent physician groups provided higher quality and lower cost care compared to employed or physicians who were employed by hospitals and that there was also some nexus between the size of the physician group and being able to demonstrate a better quality and lower cost.

Q. And did the article identify a possible reason or reasons why hospital-employed physicians might be more expensive than independent physicians?

A. It didn't establish. I think, as a matter of record, it hypothesized that it might be due to higher utilization of the hospitals and the associated higher costs associated with providing services in hospitals versus in ambulatory care settings. But they were clear to say that that wasn't the primary focus of their investigation.

Q. Okay. Fair point.

Dr. Enthoven put emphasis on a report prepared by the Berkeley Forum. Are you familiar with the Berkeley Forum?

A. I am.

Q. Do you know the author of that study?

A. Yeah. Steve Shortell is the former dean of the School of Public Health at Berkeley. I sit on his policy advisory board.

Q. Now, Dr. Enthoven focused on the notion that there

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should be more in the way of clinical integration in California.

Did the study also say anything about market concentration and healthcare prices?

A. The study did. And recognizing that California has already relatively high penetration of integrated delivery systems, but clearly it said that there were -- that they projected that there would be benefit from increasing the amount of integrated care, but they also raised the concern that competition was also necessary; that if too much market share were concentrated, there would be concern about whether the hoped-for economies and improvements in quality would be realized.

Q. Turning to the next --

MR. KEITH: Your Honor, sorry to interrupt, but I don't believe that Dr. Kizer's report actually cites the Berkeley study or the Berkeley report. This is the first we have heard his views on it.

MR. GREENE: Neither did Dr. Enthoven's report cite the Berkeley Forum. This came up in court last week. And he is simply a rebuttal witness responding to a specific statement by Dr. Enthoven, essentially, his opposite number looking at quality issues.

MR. KEITH: I don't recall, to be perfectly honest, Your Honor, if he did or didn't.

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THE COURT: Well, I'll give you some leeway here. And if it wasn't, then we'll strike the testimony.

Go ahead.

BY MR. GREENE:

Q. Turning to the next slide, Doctor. This relates to the core theory. What is your understanding of the defendants' claims with respect to a core -- a necessary core or nucleus of physicians?

A. The defendants have claimed that there is a requisite core of employed physicians as necessary -- excuse me -- to provide integrated care. And this is a theory that Professor Enthoven has espoused. It's an interesting theory that certainly at the moment is not supported by empirical evidence.

And in listening to or reviewing Dr. Enthoven's comments in that regard, it's not entirely clear what that core might -- that core number of physicians might need to be.

Q. Now, in forming your opinion with respect to the core, did you -- did you find that your view was affirmed by Dr. Enthoven's trial testimony?

A. I thought Professor Enthoven was clear that it is, as in this quote -- as he says, it's a judgment out of unsupported opinion, which I think is another way of saying what I was saying, that it's a theory that's not supported by empirical data.

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Q. But focusing on empirical data, to your knowledge, are there any empirical studies supporting Dr. Enthoven's opinion?

A. I'm not aware of a single study that supports the theory.

Q. Now, looking at this slide, are you suggesting by this slide that you agree with Dr. Enthoven about the need for a core or nucleus of employed physicians?

A. No. I think in recognizing that it is a theory, in the eventuality that it might at some point be shown to have some empirical evidence, I was taking it the next step further in saying: If, in fact, the theory were true, hypothetically, the condition appears to already be met because St. Luke's has a number of employed primary care physicians already, and it's just not clear why they would need to employ more to support that theory.

Q. So essentially, as I understand what you're saying, is assuming arguendo that the core ultimately has some basis, you think these points respond to that?

A. I -- again, the slide would put -- was put forth in recognition, whatever that legal term was that you used.

Q. I said arguendo.

A. That if it were found to be true, that the condition appears to have already have been met.

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Q. Okay. Thank you, Doctor.

Let's turn to the next topic, which is this interesting one of healthcare IT, which breaks down into electronic medical records and what's been described as data analytics tools.

What are your conclusions with respect to St. Luke's claim with respect to health IT?

A. Well, you know, the -- again, it would be adequate or it would appropriately characterize the situation to say that there is truly a revolution going on in health IT in recent years and that the health IT tools that are needed -- electronic health records, data analytic tools, and there are others that aren't mentioned here -- are already available to Saltzer, and they appear to be effectively using them.

Q. Okay. And what about specifically the benefits of WhiteCloud?

A. It was not clear to me from the evidence I reviewed that the WhiteCloud tool has provided any benefits with regard to patient care for Saltzer or that it is likely to in the future.

Q. Okay. Turning to the next slide, Doctor. Did Dr. Peterman's trial testimony affirm your opinion on the IT issues?

MR. KEITH: Objection, Your Honor. This is also

something that was not in the -- any of Dr. Kizer's reports; that is, an analysis of Dr. Peterman's use of Primary Health Medical Group's use of eClinicalWorks. Again, it was a plaintiff witness, so --

MR. GREENE: He did, Dr. Kizer, in his report did articulate the fact that other systems could certainly provide similar levels of function --

THE COURT: And he can testify to what those are to the extent they are disclosed in the report.

MR. GREENE: Actually, let me swing back to that, Your Honor.

THE COURT: All right.

MR. GREENE: We're on the clock, as they say.

BY MR. GREENE:

Q. Dr. Kizer, separate and apart from Dr. Peterman's trial testimony, is Epic, the system being used by St. Luke's, so unique that it is not comparable to other EMRs?

A. Epic is one of quite a number of electronic health records that are available to hospitals and doctors and other providers today.

Q. And is it the case that large systems usually or universally choose Epic as opposed to other systems?

A. No. I mean, Epic has a good footprint. They are one of the more popular, but there are others. You know,

for example, when I was at Intermountain recently, as was announced in the media, they have recently selected Cerner as their electronic health record.

MR. KEITH: Objection, Your Honor, move to strike. Not in the report.

THE COURT: I'll sustain the objection.

MR. GREENE: Your Honor, if I may. This notion that Epic is somehow unique is shot through Dr. Enthoven's report. And it's very clear when you review Dr. Kizer's report that he took every possible opportunity to explain that that was not true. This is just one example that illuminates his firm opinion.

THE COURT: Explain it without the example. Let's go ahead and move on.

MR. GREENE: Okay. Thank you, Your Honor.

THE COURT: I think the subject matter itself is contained in the report, but the reasons for the opinion also have to be there. And I think that's the objection Mr. Keith is making. Proceed.

MR. GREENE: Thank you, Your Honor.

BY MR. GREENE:

Q. Dr. Kizer, to the extent you know, is eClinicalWorks certified by CCHIT with respect to its capabilities?

MR. KEITH: Objection, Your Honor. Also not

disclosed in any of the reports.

THE COURT: Counsel, refresh my memory on CCHIT. I assume that's one of the institutions in California you're working for?

THE WITNESS: CCHIT is the Commission -- Certifying Commission for Health Information Technology used by the federal government.

THE COURT: What's the objection, Mr. Keith?

MR. KEITH: The objection is simply that this testimony about whether eClinicalWorks is or is not qualified for meaningful use credits is not in Dr. Kizer's report.

THE COURT: Well, Mr. Greene.

MR. GREENE: CCHIT is the normal regulatory structure that all EMRs must deal with for various public purposes and private purposes as well. Again, it goes to his overarching conclusions.

THE COURT: I know what it goes to. The question is: Was it disclosed or is it part of -- I mean, he's been --

MR. GREENE: In fairness, Your Honor, it was not specifically disclosed.

THE COURT: Let's go ahead and move on, then.

BY MR. GREENE:

Q. Now, Dr. Kizer, over time, do you expect EMR --

what is your expectation with respect to EMR technology in the future?

A. Well, I think electronic health records and other health information technology is undergoing the same rapid evolution that we see in other types of electronic gadgetry, whether iPhones or any of the other things. And it's progressing exceedingly rapidly. And what is state-of-the-art today may be obsolete in two or three years. It's just this is one of those incredibly rapidly developing areas of technology.

Q. And in this space, based on your knowledge both as a board member of an EMR company and your various other obligations and duties, is interoperability a key point of competition in this industry?

MR. KEITH: Objection, Your Honor. Not disclosed in the reports.

MR. GREENE: Interoperability was fully discussed in the report, and its importance was noted by Dr. Kizer.

THE COURT: I'm going to allow it. If you can show it was not, we can strike it later. Let's go ahead and proceed.

THE WITNESS: Well, interoperability is not just a -- something for the industry. I mean, it's a matter of federal policy and, you know, national policy that we have to move to interoperable health records.

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BY MR. GREENE:
Q. Okay. Let's turn to the next slide, Doctor. This relates to the St. Luke's Affiliate EMR program. What's your understanding of this program?
A. My understanding of the Affiliate EMR program is that it is a program that is in -- still in development. It's about to be rolled out, but it would allow independent physicians access and use of the Epic tool that St. Luke's uses.
Q. And is it your understanding that this is going to be rolled out to independent physicians?
A. It's my understanding that that is the purpose of the Affiliate program, is to make it available to independent physicians.
Q. And do you know if there has been a pilot group already selected for that purpose?
A. It's my understanding that the Women's Health Group is going to be the pilot site.
Q. And do you know if other groups have expressed an interest in participating in the program?
A. It's, again, my understanding that St. Luke's is interested in others participating and that others have expressed potential interest.
Q. Does it -- given your background, does it surprise you that St. Luke's has not acted earlier to develop

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interfaces with major physician groups in Idaho?
A. Well, I think that's -- I'm not entirely sure what you're asking there, but if the intent -- if one's intent is to optimize quality and lower costs, you want maximum ability of information, which means that you would want to be able to connect with as many other providers as possible and share information.
Q. Let's turn to the next slide, Doctor. What is this slide telling us?
A. This slide has to do with the Idaho Health Data Exchange, which was mentioned earlier, is a health information exchange technology, which is a -- again, a health information technology tool that is rapidly evolving and that is designed to facilitate interoperability between different types of electronic health records that may be used by providers.
Q. And is interoperability through a health information exchange an alternative to being employed by St. Luke's to get clinical information?
A. The health information exchange is intended to support the exchange of information between providers who are using different types of electronic health records, such as might occur in the case of independent physicians interfacing with hospitals of different types.
Q. Now, Dr. Chasin in his trial testimony suggested

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that a barrier to use is the notion that there is a portal, that it would take an amount of time to access the portal and get the clinical information. Do you regard that as a problem?
MR. KEITH: Objection, Your Honor. It's responsive to something that I'm sure was not raised at the time. It's not in his report.
MR. GREENE: Let me unhinge it from Dr. Chasin.
THE COURT: All right. Thank you.
MR. GREENE: You're welcome.
BY MR. GREENE:
Q. Dr. Kizer, is it the case that -- does it take an amount of time typically to query an HIE for clinical information?
A. There is a certain amount of time that would be required, but it's measured in seconds or minutes. And as a former emergency physician who spent a lot of time in critical care situations where every second counts, I mean, I look at this from that perspective of an emergency physician and don't see this as a major barrier.
You know, it's the type thing you might ask the nurse or the clerk to access, and you get the information. And I just don't see it as a big issue.
Q. So it wouldn't be a problem from your perspective?
A. Well, I don't dispute that it might take, you

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know, some -- a couple of minutes to access it. I just don't see that functionally as a problem.
Q. And could it be less than a couple of minutes?
A. It could be, as I said, seconds to minutes. It depends on a lot of local and specific circumstances.
Q. Now, is it the case, Doctor, that various -- these health information exchanges across the United States are, by and large, funded by federal grants; is that correct?
A. Part of ARRA, or the HITECH Act, which is part of the American Recovery and Reinvestment Act, was specifically provided many billions of dollars to catalyze the development and implementation of both electronic health records and health information exchange in communities across the United States.
Q. And are the initial grants about to run out in March or so of next year?
A. Actually, the grants -- and at the end of this year, and then there is two or three months to tie things up. I mean, we're under that same pressure in California, as are all other states, which means that we are looking for sustainable business models.
Q. And is the information contained or managed by the HIEs valuable information?
A. Of course, it's valuable.
Q. And do you have any insurmountable concerns about

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the ability of at least the California HIEs to be able to find a business model that would be sustaining?

A. We have a number of HIEs in the state that certainly appear that they will have sustainable business models. I can think of one immediately that is self-supporting right now.

Q. Now, an HIE is a kind of interface; correct?

A. Yes.

Q. And are there off-the-shelf interface products?

A. Most interfaces have to be designed unless there is standards that allow the admissibility of information between the systems because they are designed on the same standards.

Q. And are major companies banding together to improve EMR interoperability?

A. Again, interoperability is both a business imperative as well as national policy. And I think, you know, one example of where you see competing entities coming together as the CommonWell Alliance that was recently announced between Cerner, Allscripts, and Athena, and some other entities.

THE COURT: Counsel, we have gone beyond probably where we take the break. I wasn't sure --

MR. GREENE: Let me ask two more.

MR. KEITH: And I have an objection and move to

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strike testimony with respect to the agreement that he just referenced on interoperability between Cerner and Athena and the like. I don't think that was disclosed to us.

MR. GREENE: In fairness, Your Honor, it was not specifically disclosed because it just happened in the last month. But he did indicate from an overarching perspective that this was --

THE COURT: Counsel, here is the problem -- and I'm sure those perhaps in the audience are wondering why do we exclude things that should be the most pertinent, relevant things that happened in the last two or three weeks. The problem is both sides have not had a chance to address that. It's never more so than in the case of expert testimony.

I would be amenable, given the fluid nature of all this, to permit some supplementation, but the problem is it's just going to open up the entire record, and it's just never going to end.

So, again, at this point, I'm going to have to sustain the objection unless not only was the opinion stated but also this reason for the opinion stated in the Rule 26 expert report.

Just for those in the audience, so they understand, in essence, we kind of freeze the case at a certain point. And with regard to experts, it's at the filing of their rebuttal

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expert report, so that we don't have to be constantly taking new depositions, filing new reports right through the date of trial. It's just a function of having to take a snapshot in time and then working with that.

So I'm going to sustain the objection.

MR. GREENE: Thank you, Your Honor.

THE COURT: Mr. Greene, go ahead and ask your one or two more questions that you had.

BY MR. GREENE:

Q. Dr. Kizer, are interfaces allowing for interoperability among EMRs unusual or difficult to create?

A. It's a routine part of the business.

MR. GREENE: I think that reaches a natural breaking point, Your Honor.

THE COURT: All right. Very good. Then, Counsel, let me inquire: What do you anticipate and how long are we going to need to go? I'm sure Mr. Keith will keep his cross very, very short, so we won't need to worry.

MR. GREENE: Bless him if he does do that. Yeah, I think maybe another 15 minutes of direct, Your Honor.

THE COURT: And other witnesses?

MR. GREENE: We do have Dr. Polk lined up, and I believe Dr. Polk is expected to testify potentially for an hour.

MS. DUKE: Forty-five minutes to an hour,

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Your Honor.

THE COURT: Take the break now, and we may need to take another break later in the day as well if we go much beyond 2:30. We will be in recess for 15 minutes.

(Recess.)

****** COURTROOM REMAINS OPEN TO THE PUBLIC ******

THE COURT: Dr. Kizer, I'll remind you you are still under oath.

Mr. Greene, you may resume your direct examination.

THE WITNESS: Thank you, Your Honor.

MR. GREENE: Thank you, Your Honor.

BY MR. GREENE:

Q. Moving to the next slide, Doctor, based on His Honor's decision earlier in the day, I'm going to switch to the next slide.

And is it your understanding that St. Luke's plans to make WhiteCloud available to independent physicians when finally operational?

A. It is.

Q. And as a member of the Select Medical Network, is it your understanding that an independent Saltzer could use WhiteCloud?

A. It is.

Q. Just rattling my papers here, Doctor. My apologies.

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Now, if an independent Saltzer chose not to use WhiteCloud, would that be a problem from your perspective?

A. I do not think it would be because there are many other options available.

Q. And what are the kinds of options that may be available as alternatives to the WhiteCloud system?

A. Well, similar to essentially everything else in the health information technology arena, there has been an explosion of vendors who offer the services in recent years, and there are many options that would be available and, you know, Explorys, Humedica, Pervasive Health, Clinical Query, and -- you know, there are lots.

Q. Okay. And are there --

MR. KEITH: Object to form, Your Honor. Move to strike. I don't believe any of those were disclosed in his report.

THE COURT: Mr. Greene.

MR. GREENE: It was disclosed in his report, Your Honor, that he -- his view was that any number of systems would work properly. At paragraph 99, he wrote that "Today's healthcare providers can avail themselves of multiple health IT tools that perform the same basic functions as Epic and WhiteCloud and which can be used to support clinical integration."

In paragraph 98, he concluded that "There is no

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compelling reason that an independent Saltzer is unlikely to spend its resources to achieve independently such benefits."

I think that fairly covers the point.

THE COURT: Counsel, is this in the reply or in the original?

MR. GREENE: It's in the reply, Your Honor, August 1st, 2013.

MR. KEITH: And just to be clear, Your Honor, we don't have an objection to the testimony as Mr. Greene has just recited it from the reports. It's providing the additional detail he did not provide in the report, which is this system, that system, the particulars.

THE COURT: Well, Counsel, I think at some point, I mean, there is some level -- I hate the word "granularity," but it kind of fits here. At some point, I mean, he has disclosed in paragraph 99 that there are multiple health IT tools that would perform the same basic function as Epic and WhiteCloud. And I think --

MR. KEITH: Your Honor, my concern is, had he disclosed the names, we certainly would have followed up on them in particular at the deposition. But having stated the testimony so generally --

MR. GREENE: And not to be argumentative, Mr. Keith did have the opportunity to ask about those paragraphs in Dr. Kizer's report at the time.

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THE COURT: Well, I'm going to allow some leeway here. We are just identifying what is medically -- what is clearly available in the market, I'm assuming. I know there may be a fine line here, but I think here we are talking more about something that's available on the market as opposed to actual practices that are being performed and systems that are being developed, which I think would require more of a particularized inquiry, and I think would be more problematic for St. Luke's. But I think to simply reveal other Epic competitors is, I think, within the four corners of paragraph 99 of the reply.

So you may go ahead.

MR. GREENE: Thank you, Your Honor.

BY MR. GREENE:

Q. What are the kinds of functionalities that these sorts of products provide that distinguish them in the marketplace?

A. Well, I think in looking at a data analytics tool, it's important to be able to connect with the different databases like the electronic health record and pharmaceutical use databases and financial or billing claims systems to pull the information, identify the individuals who are at risk, and then be able to predict what their likely problems might be over the next three months, the next 12 months, the next 18 months. And so having that

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predictive modeling capability is an essential part of a data analytics tool if it's going to be useful.

Q. And is that particularly useful for purposes of engaging in risk-based contracting?

A. It's, for all intents and purposes, essential. To do risk-based contracting, you have to have a predictive modeling capability so you can identify who is at risk of an untoward event and fashion your interventions appropriately.

Q. And is interoperability a major feature or a feature being touted by these various systems?

A. Again, interoperability is one of those core functionalities that would be expected.

Q. And why is that important?

A. Again, it needs to be able to -- the analytics tool needs to be able to connect to multiple different databases: the claims payment databases, the electronic health record information, the pharmaceutical use data. And if one is servicing multiple providers that may have different instruments or technology in that regard, it's important to be able to -- to be interoperable with all of them.

Q. Okay. From your perspective, Doctor, does a physician group need the financial resources of a hospital-based system to acquire and effectively use health analytic products?

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MR. KEITH: Objection, Your Honor. Now, this question I actually asked in the deposition as to what these particular types of products cost, and he told me he didn't know. So for him to testify as to whether he can purchase --

THE COURT: Counsel?

MR. GREENE: I think -- I think his source of knowledge in terms of his ability to answer this question depends, frankly, on the fact that these systems, these kinds of tools are being purchased by large and small systems throughout the country. So his source of knowledge is not based on the price of the product per unit, but rather the fact that it's being adopted by small and large systems.

MR. KEITH: I'm not certain that the fact -- that fact is in the reports either, that these systems are being acquired by large and small practices across the country.

THE COURT: I think, at this point, I'm going to allow it. Proceed.

BY MR. GREENE:

Q. Does a physician group need the financial resources of a hospital-based system to acquire and effectively use health analytic products?

A. The -- these tools are used widely by physician practices of varying sizes, by physician hospital

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organizations, by hospitals, by health systems. They are, again, part of the basic landscape going forward. And while I may not know the exact price of them, I know that they are being widely utilized.

Q. Okay. Now, Doctor, have you seen any evidence, any evidence suggesting the WhiteCloud tool has or will positively change the Saltzer physicians' present practices?

A. No. I have seen no evidence that it has positively impacted the care that's being provided by Saltzer or have reason to believe that it will in the future.

Q. Okay. Let's turn to the next that you analyzed. What are your conclusions with respect to aligning incentives?

A. Well, in general, I think that that's one of those functionalities that is required to optimize integrated patient care that one has to align those -- the incentives. I concluded, based on the -- my review of the evidence, that the -- what I've seen of the St. Luke's-Saltzer PSA does not align incentives to provide quality care, and certainly employment of physicians in general doesn't a priori align incentives per se and that there are alternative financial models or payment structures that are being widely utilized and can be utilized to achieve those same purposes.

Q. Turning to the next slide, Doctor, what is this

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slide showing us?

A. This is just a highlighted section of the Saltzer -- St. Luke's-Saltzer PSA in which certain sections have been highlighted indicating that the -- the practice of the group will not be changed as a result of the acquisition; ie, that they are not putting in place quality improvements or other incentives to change practice. They are just letting things continue basically as they have been in the past.

Q. So just to make sure the record is clear, what is a wRVU?

A. A wRVU stands for work relative value unit, and relative value units are a basic unit by which different types of practitioners are compensated for their services.

Q. Okay. And so is the essence of this agreement from your perspective that the more procedures a Saltzer physician does, the more he or she gets paid?

A. There is nothing in this PSA that focuses on improving quality or changing the incentives, other than the volume-based incentives that existed prior to the acquisition.

Q. Now, I understand that there -- or do you understand that this contract was relatively recently amended?

A. I was provided the opportunity to see a short

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amendment to this. It was effected, I understand, very recently.

Q. Okay. And was that just before trial, approximately?

A. I don't recall the exact date, but it was certainly within the last few weeks.

Q. Okay. And does that -- what did that provide for?

A. With regard to quality, it didn't provide for anything specific. It basically -- how should -- it indicated that they agreed to agree to work out something over the next two years that would potentially align up to 20 percent of a physician's payment towards quality. But there were no specifics included in that amendment, so I don't know what to make of it.

Q. Okay. And would it be the case, from your perspective, Doctor, that if Saltzer remained an independent practice, that those kinds of incentives could be built into their pay?

A. That is correct. And that is, in fact, being done with other groups across the country.

Q. And that brings us to our next slide, which is -- you know, does this summarize a variety of programs that provide for the sharing of savings or the taking of risks by providers?

A. Again, this was intended just to provide some

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illustrations of the types of models that are being pursued across the country by the federal government and the Medicare program by private payors, commercial payors; that there is a variety of instruments, if you will, in which to align payment with improved quality of care.

Q. And is the Medicare Shared Savings Program usually thought of as a so-called gain-sharing program?

A. The Medicare Shared Savings Program is basically designed to -- for what might be considered upside risk; in other words, that if you meet certain performance goals, then you can share in some of the savings that would be accrued from meeting those goals. But it doesn't necessarily provide for a downside risk.

Q. And do these -- do gain-sharing contracts actually work to reduce costs?

A. They have been shown to reduce costs.

Q. Is there any empirical evidence or empirical studies that indicate that gain-sharing is less good than other forms of payment?

MR. KEITH: Objection, Your Honor. And I apologize if this is in the report, but I don't think it is.

THE COURT: Counsel, Mr. Greene, if it's not, then I'll sustain the objection.

MR. GREENE: Fair point.

BY MR. GREENE:

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Q. Could Saltzer, from your perspective, Doctor, participate in risk-based contracts through its participation in various networks, including the Select Medical Network?

A. It could.

Q. Okay. Let's turn to your conclusions, Doctor. What are you -- remind us, what are your basic conclusions with respect to the opinions you have been asked to render.

A. On the issues that I was asked to opine upon is, basically, I concluded that the claims about improved quality are speculative, and it's certainly not related to the acquisition per se and that the transaction is not necessary for either Saltzer or St. Luke's to provide improved quality of care.

I concluded that the core theory, as we talked about earlier, is just that; it's an unsupported theory. I concluded that independent physicians currently use and have available to them a wide array of electronic medical records and data analytics tools and other IT instruments if they choose to use them and that the -- this transaction per se is neither sufficient, nor necessary for moving away from a fee-for-service payment model to other global payment or at-risk payment models.

Q. Thank you, Doctor.

Now, earlier in your testimony, I think I skipped over

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a point. Getting back to the form versus function points you were making, you mentioned, I think, in passing that while employment or specific economic structures might not be the driving -- drivers behind improved quality, there might be other functionalities that do provide acceleration or incentives to improve care.

What -- can you give us a few examples of those functionalities?

A. Sure. There's a number of functionalities that have been associated with providing integrated patient care, which is what we're really talking about. And these functionalities include having very clear objectives and goals about where one wants to go; having a health information technology or other information management infrastructure that allows the free mobility of information between and amongst providers so that the information is present at the time and point of care; having a -- an accountability and performance management system so that one can continually assess what level of performance -- ie, quality or efficiency -- is being achieved. It requires aligning incentives, as we were just talking about a moment ago; having strong clinical leadership.

And, I mean, I could go on, but there's, depending on how you count them, probably eight or nine or so core functionalities which, again, I think the VA provides very

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instructive experiential information or data in this regard in that physicians were all employed before I got there, care was highly fragmented.

We implemented a number of these functionalities. Care dramatically improved. Cost of care went down. Patient satisfaction improved, and none of -- of changing how the organization functioned was related to employment of physicians per se.

Q. So just to ask the most basic question: Are any of those functionalities that you've described dependent upon the employment of physicians?

A. No, they are not. They are organizational functionalities that can be achieved independent of how physicians may be organized or associated with the organization.

MR. GREENE: Thank you, Doctor.

Your Honor, that ends my questioning until I get the opportunity to go after Mr. Keith.

THE COURT: Mr. Keith.

MR. KEITH: Thank you, Your Honor.

CROSS-EXAMINATION

BY MR. KEITH:

Q. Good afternoon, Dr. Kizer.

A. Good afternoon, Mr. Keith.

MR. KEITH: Can we switch over the monitor?

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Great.
BY MR. KEITH:
Q. Dr. Kizer, I have a few quick cleanup points that I want to get to and then get to the bulk of my questions.
You talked a fair bit about the St. Luke's Affiliate EMR Program, the Idaho Health Data Exchange, and interoperability of various -- of various electronic health records. And the court heard testimony in this trial from Dr. Marc Chasin, who is St. Luke's chief medical information officer also on the board of the Idaho Health Data Exchange.
I take it you don't personally use the Idaho Health Data Exchange; correct?
A. I do not.
Q. And as between you and a board member on the Idaho Health Data Exchange, you're not suggesting that the court should credit your understanding of the functionality of that system, are you?
A. I am not quite sure how to respond to that question.
Q. Well, if you and Dr. Chasin testify inconsistently, is it your position that the court ought to credit your testimony and not Dr. Chasin?
A. I think that's a judgment made by the court.
Q. Okay. So you consider yourself an expert as a -- on the level of a board member of the Idaho Health Data

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Exchange on its operations and functionality?
A. I would not say that my knowledge of the day-to-day operations of the Idaho Health Data Exchange is the same as one of their board members.
Q. Correct. And, similarly, your understanding of the interoperability and the connectivity of the Idaho Health Data Exchange with electronic health records would not be on a par with a board member of the Idaho Health Data Exchange; correct?
A. I would have to agree with that.
Q. Same question as to the St. Luke's Affiliate EMR Program. As between you and Dr. Chasin, you would agree with me that Dr. Chasin knows more about the Affiliate EMR Program that St. Luke's will offer; correct?
A. Well, since I don't know what Dr. Chasin knows, I can't a priori agree with your assertion.
Q. You think you know as much about the St. Luke's Affiliate Program as St. Luke's chief medical information officer?
A. Well, my same comment would apply in that I don't know what his level of knowledge is, so I can't compare.
Q. And so if you and Dr. Chasin testify inconsistently on a matter of fact having to do with the St. Luke's Affiliate EMR Program, you're telling the court that it ought to credit your testimony?

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A. I don't recall testifying to that effect.
Q. Okay. You would agree that that would not be appropriate; correct?
A. I don't recall testifying to that either.
Q. You're indifferent as between them?
A. I think the court is very capable of making that judgment.
Q. You don't -- you don't purport to be as knowledgeable about the St. Luke's Affiliate EMR Program as St. Luke's chief medical information officer, do you?
A. My knowledge comes from the evidence that was provided. Whether that is the same as his, again, I can't say. I certainly would expect that he would have more day-to-day familiarity with it.
Q. And in terms of St. Luke's electronic health records' ability to interface with other electronic health records used by independent practice groups, that's another issue on which you are not as well-versed as the St. Luke's chief medical information officer; correct?
A. Again, I would not profess to know all of the day-to-day issues. I have a general industry perspective from my involvement in this area.
Q. So you have a general industry perspective, but you don't purport to be an expert on the -- the day-to-day operations of the St. Luke's electronic health record;

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correct?
A. No. I rely on the information that's been provided to me.
Q. Now, have you actually put your hands on getting a -- an electronic health record to interoperate with some other database? I mean, actually done it yourself?
A. No, I have not done it myself. But when I was CEO of Medsphere, I certainly had staff that did that as a routine part of their job.
Q. And you would agree that that can be an expensive process; correct?
A. It can involve a significant amount of funding.
Q. And it could take a considerable amount of time to create the interface between two electronic health record systems; correct?
A. I'm not sure what you mean by "considerable," but it is something that obviously does take some time, maybe from days to -- well, typically, a few days.
Q. It can take weeks, too; right?
A. I suppose it could.
Q. Right. Even months, maybe?
A. I suppose it could. I'm not personally aware of such instances.
Q. Now, you and Professor Enthoven agree on a few things. I just want to spell those out. You and Professor

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Enthoven agree that fragmentation of care is a real problem in today's healthcare system; correct?

A. Yes.

Q. And you agree that fee-for-service reimbursement does not facilitate or naturally lead to integration of care; correct?

A. I would agree in that regard as well.

Q. And you agree with Dr. Enthoven that what should be provided to patients is integrated care and that that needs to be delivered by an appropriate organizational structure; correct?

A. I agree insofar as we certainly want to provide integrated patient care.

Q. Do you also agree that, in order to provide integrated care, there must be an appropriate organizational structure within which to provide that care?

A. Yes. I'm sorry; I would agree with that as well.

Q. And it's your belief, in fact, that the fee-for-service method of payment for healthcare services is a significant factor contributing to the disproportionate and unsustainable rise of U.S. healthcare costs; correct?

A. I would agree with that.

Q. And that's because the fee-for-service system pays for volume rather than the quality or necessity of the services provided and, with few exceptions, pays only for

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face-to-face interactions between patients and caregivers; correct?

A. That is correct.

Q. Now, you mentioned the transformation at the Veterans Health Administration. And I want to talk to you a little bit about the details of that.

Among the factors that contributed to the successful clinical integration, the transformation of the VHA, was the shift away from something like fee-for-service to capitated payment for services provided by VHA clinicians; correct?

A. We changed the payment model. And while we don't normally think of government programs as having payment models, there has to be a method for allocating resources among the different hospitals and other sites of care, and we did change that payment model.

Q. And, generally speaking, you changed that model from something like fee-for-service to something like capitated payment; correct?

A. We changed it to what would be called today a global payment system, which is a capitation-like payment model.

Q. And do you disagree -- because I think you told me this at your deposition. Do you disagree that the old system was something like fee-for-service?

A. It was something like fee-for-service. One of the

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problems was that no one knew quite what it was.

Q. And it's your belief that, on the commercial side, providers transition away from fee-for-service to full-risk contracts with similarly aligned financial incentives towards better care and lower cost; correct?

A. I think the industry is certainly moving towards more and different types of at-risk contracts.

Q. Well, that's true but not my question. My question is: The transition away from fee-for-service to full-risk contracts, you believe, will align financial incentives towards better care at lower cost like the change in payment methodology did for the VHA; correct?

A. Yes. I would agree conceptually that that's correct.

Q. Now, counsel for the government asked you, generally speaking, what the hallmarks of a clinically integrated organization were. And I want to get into a little more of the brass tacks, so I've created a demonstrative that takes directly from your report and just copies what you've said.

MR. KEITH: So can we put that up? I think we have a copy.

THE COURT: Do we have an exhibit number?

MR. KEITH: It is 5137.

THE COURT: And I actually neglected to establish

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the exhibit number for the demonstratives used earlier as well. Perhaps, at an appropriate time, counsel can indicate that number. Mr. Herrick, perhaps at a break, you can do that.

Proceed.

BY MR. KEITH:

Q. So I just want to run through these attributes with you to establish a record of what you view as the key functional abilities of organizations achieving clinical integration.

One, a common vision for healthcare -- a common vision of healthcare delivery; two, shared and widely understood clinical objectives and goals; three, information management tools and other infrastructure to monitor, analyze, and affect processes and quality of care and clinical outcomes; and, four, policies and procedures for coordinating a care -- coordinating care across conditions, providers, settings, and time.

Have I fairly represented, at least this far in the list, your views of the key attributes of organizations achieving clinical integration?

A. It sounds consistent with what I said. I would have to check.

Q. Well, we're not done with the list, so let's go to the next page. So I believe we are on five.

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A performance management system that consistently measures and monitors clinical performance by use of standardized performance measures; six, a patient-centric and population health focus; seven, shared financial risks and rewards for clinical outcomes; and, eight, improved clinical efficacy.

Did I accurately represent your views, now having seen the full list, of the key functional abilities of clinically integrated organizations?

A. That appears to be what I put in my report.

Q. Okay. Now, bear with me here; I just want to make a full record. There -- you provide in your reports specific examples of activities, tools, and support systems used to achieve clinical integration. And I want to run through what those are, so let's go to the next page.

You articulate that these are the things you want to see being used or being done by organizations that are clinically integrated.

Utilization and demand management programs; that's one. Common patient identifiers, two. EMR, or electronic medical record, for three. Clinical decision support and other information management tools, four. And clinical guidelines and care pathways.

Not through with the list yet, but so far, have I got your report correct?

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A. You appear to.

Q. Okay. All right. Four more.

Performance measurement and other continuous quality improvement activities, case management and disease management programs, clinical service lines, and disease registries.

With that now the full list, have I accurately depicted the activities, tools, and support systems that you believe organizations that are achieving clinical integration use?

A. I believe that you've adequately reflected what was in my report.

Q. Last one; I promise. I wanted to go through the elements of EMR and health IT that you've identified in your report as being particularly important. And you write: Today EMRs and health IT have a critically important role in -- and there are three things it has a critically important role in:

Collating and sharing patient-specific information between and among caregivers and other service providers;

Two, assisting clinicians through clinical decision support software that aids medical decision-making about which tests or treatments should be pursued and in what sequence or combination;

And lastly, facilitating analysis of information about groups of patients having certain conditions or needs, among

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other important users. That's misspelled, "uses." Or maybe I've misread it.

Did I fairly represent on this demonstrative your opinion as reflected in your report?

A. You appear to have.

Q. And speaking of EMRs, it's your view that the implementation of a system-wide electronic health record system was an essential part of the transformation of the Veterans Health Administration that you led; correct?

A. It was a key element of that change.

Q. I believe you have -- you have written an article that calls it an essential part. Would you dispute that?

A. No, I don't.

Q. And even today, you regard implementation of a systemwide electronic health record as essential for providers even outside the VHA to engage in clinical integration; correct?

A. I think, as I have testified already today, the healthcare of the future is going to have to have electronic health records and other information management tools as a core part of their infrastructure.

Q. And you think those electronic health records need to be systemwide; correct?

A. They need to certainly provide access to information across all parts of the system.

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Q. Now, you testified, generally speaking, that it's your view that Saltzer has reaped all of the benefits of using an electronic health record system.

(Phone ringing.)

MR. KEITH: Sorry about that.

BY MR. KEITH:

Q. Getting back to where I was, you testified that Saltzer has already reaped the benefits of using an electronic health record. And you understand that Saltzer uses eClinicalWorks; correct?

A. That's my understanding.

Q. But you also told me during your deposition that not every implementation of eClinicalWorks looks and functions the same; right?

A. That is correct. I mean, these technologies are continually involving, and they can be implemented differently in different settings.

Q. Right. In some settings, some modules can be activated, some modules deactivated, some systems functional, some systems not functional; correct?

A. That's correct.

Q. And specifically with respect to the Saltzer electronic health record, eClinicalWorks, you don't know whether Saltzer routinely measured and tracked its clinical performance, do you?

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A. I don't know that for sure.
Q. And you don't know whether Saltzer's eClinicalWorks system interfaced or interconnected with the Idaho Health Data Exchange, do you?
A. I understood that it did.
Q. You understood that it did? What was the basis of that understanding?
A. I recall it being mentioned somewhere in there. If that's not correct, then feel free to correct me.
MR. KEITH: Now, let's go back to the demonstrative we were just looking at, Mr. Chase. And I need to write this number down so I don't forget it, 5137.
BY MR. KEITH:
Q. And on the last page, you describe EMRs as being critically important for purposes, among others, of "providing clinical decision support." Do you see that?
A. I do.
Q. And you don't know whether Saltzer's eClinicalWorks system provides clinical decision support, do you?
A. I do not know that.
Q. In fact, at the time of your deposition, you had no idea whether eClinicalWorks even offered a module that provided clinical decision support; correct?
A. That is correct.

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Q. And you don't know whether Saltzer's eClinicalWorks system provides, for example, real-time order checking or clinical alerts or those sorts of things, do you?
A. I don't know that. I know that it's certified by the certification commission for HIT as a complete electronic health record.
MR. KEITH: I move to strike that, Your Honor, as testimony we have already objected to.
MR. GREENE: Your Honor, that was directly responsive to the question posed by counsel.
MR. KEITH: It was not responsive.
THE COURT: The question had to do with whether Saltzer's eClinicalWorks --
MR. KEITH: In particular, its implementation had that functionality.
THE COURT: With that understanding, I'll sustain the objection.
BY MR. KEITH:
Q. And you understand, don't you, that the Epic system that St. Luke's is implementing has the functionalities that we just talked about that are what you regard critically important for integrated care; correct?
A. I believe Professor Enthoven stated that in his deposition.

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Q. Well, you actually believe that to be true, don't you?
A. I do not have independent knowledge that that's true, but in general, Epic provides those services.
Q. So you know in general that Epic provides the kinds of services you describe as critically important to clinically integrated care?
A. Right. My knowledge of Epic is in the same vein as eClinicalWorks.
Q. And at the time of your deposition, you understood that Epic and eClinicalWorks were not interoperable; correct?
A. That is correct.
Q. Now, you testified that Saltzer could get the benefit of the Epic system through the St. Luke's Affiliate EMR Program. But you understand, don't you, that there'll be a substantial cost to Saltzer to purchase Epic through that program; correct?
A. I am not aware that it's being offered for free.
Q. Well, do you understand what the costs of that -- of using the Affiliate Program will be?
A. What I understand is that St. Luke's will be subsidizing it at an 85 percent level and that -- or at least that's what has been stated in the record -- and that it has been projected that the cost might be in the range of

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30- to $35,000 a year.
And so if you do the math, that equates to something like 4- to $5,000 per physician, which would include some of the maintenance costs that are already being paid for eClinicalWorks, bringing it down further.
So I don't know exactly what the cost is, but I would imagine, based on what I have just said, that it would be somewhere in the range of 2- or $3,000 a year.
Q. In fact, the best estimate of the cost to Saltzer would be in the high six figures. That's not something you're aware of; correct?
A. I am not aware of that, and I don't know the basis for that statement.
Q. And you don't have any basis to say that Saltzer will or won't spend the money to get Epic through the Affiliate EMR Program, do you?
A. I have no way of knowing that for sure, no.
Q. Yeah. You don't know what Saltzer's financials are like; right?
A. I have not been asked to look at their financials, so I wouldn't know that.
Q. And if the transaction at issue here in this case provided Saltzer earlier access to an electronic health record like Epic that provided Saltzer with functionality that it needed but did not get through its implementation of

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eClinicalWorks, you would regard that as a potential benefit of the transaction; correct?

A. If there were no other options, that would be a potential benefit.

Q. Now, you're not aware of whether Saltzer has in-house any care management, care coordination, or similar population health management systems; correct?

A. And just to clarify the question so I respond appropriately, when you say "in-house," what do you mean by that?

Q. I mean, Saltzer, as an independent group prior to the transaction and if unwound, doesn't itself have care coordinators on staff, do they?

A. I don't know at the moment whether they have care coordinators on staff or not, but that's a resource that could be readily easily procured.

Q. At a cost; correct?

A. At a cost.

Q. And you've already told us you don't know what the finances of Saltzer are like; right?

A. That's correct.

Q. So you can't predict whether they would actually develop that kind of functionality internally.

A. I -- I don't have a basis for answering that.

Q. Now, you also testified that you thought that the

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development of the WhiteCloud tools, the clinical integration scorecard, population health management tool, that those -- the developments were sort of speculative as to whether they were going to really improve quality or lower cost. Did I correctly understand your testimony?

A. My testimony was that they have not been demonstrated to improve quality, nor did I believe that they would in the future, if that's what you're asking.

Q. And that would be something you would be interested in knowing, wouldn't you, in terms of assessing St. Luke's ability to improve quality of care at Saltzer; that is, whether it had a tool that could be used to analyze, measure, and improve quality of care?

A. What I know is that there are many such tools that would be available to them.

Q. So it wasn't important to you to better understand what the WhiteCloud tool offered; is that what you're saying?

A. Well, as you well know, the reason I participated in that WebEx that you did on WhiteCloud was towards that end.

Q. And that was a couple of weeks ago; correct?

A. I believe it was October the 8th.

Q. And were you aware that we offered that opportunity to your counsel in May?

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A. I was not aware of that.

Q. And had you been given the option, would you have been interested in taking the tour then?

A. I would have been interested in taking the tour at any time.

Q. And you don't have any understanding of what the costs is in terms of money, time, or disruption of business that it takes to integrate a new independent physician practice into the WhiteCloud tool, do you?

A. You're speaking in the abstract, so I could only say in the abstract that I don't know, and you've not provided any specific information that would help answer that more precisely.

Q. And, similarly, you don't have any idea of the cost in terms of time, money, disruption that is incurred by the independent physician group that decides to interoperate with the WhiteCloud tools; correct?

A. Well, I know, as a matter of general industry experience, that switching from eClinicalWorks to Epic will be disruptive and costly and impede the flow of patient care.

Q. And is that what you regard as necessary for Saltzer to participate in the WhiteCloud tool?

A. No. I think we have testified earlier that that's not necessary.

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Q. So my question is: Do you have any sense of the cost in time, money, and disruption for independent groups to link their electronic health record systems, whatever they may be, to the WhiteCloud tool?

A. I don't know. I do recall trying to ask that question during the WebEx and didn't get an answer.

Q. And in light of you're -- the state of your knowledge in terms of the time, money, and disruption associated on either side of the transaction with linking an independent group to WhiteCloud, you're not in a position today to say whether some, most, or all independent groups will access the WhiteCloud tool; correct?

A. I would not be prepared to speculate on that.

Q. Now, I want to talk to you a little bit about your sense of the value of employment in terms of clinical integration. And you testified that, I think, paraphrasing from your slide, that appointment of physicians has not been shown to be a superior organizational form.

And I think what you mean by that -- and you'll correct me if I'm wrong -- is that the jury is really still out on this question; right?

A. The evidence to date does not show that employment is superior to other models.

Q. Nor does it show that it's inferior to other models; correct?

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A. I would have to agree with that.
Q. So the jury is really still out on this question.
A. The jury is still out and, you know, we do have some experiential data. This was a similar dynamic that occurred in healthcare in the 1990s, at which point after which it was concluded that employment was not a particularly good option for many providers.
Q. In your view, the question of the relative importance of employment in terms of generating clinically integrated care has not been answered in the empirical literature; correct?
A. I'm sorry. Would you be so kind as to repeat the question.
Q. I would be happy to.
In your view, the question of the relative importance of employment in terms of leading to clinically integrated care has not been answered in the empirical literature.
A. That's correct.
Q. And that's -- for example, because no one has analyzed Kaiser Permanente and said, you know, absent employment but you had all the other functionalities of Kaiser, how would it have ended up; right?
A. That is correct.
Q. And the same could be said of the -- the Veterans Health Administration. No one has sat down and said, well,

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if you made all of those employed physicians independent, how would it all have ended up with all the other functionalities staying the same; correct?
A. I would not agree with that for reasons that you may not have thought about. For example, many veterans have unique problems that require certain expertise that is not widely prevalent in the private sector, as was demonstrated by the Geisinger Rural Health veterans program.
So, you know, I think the VA experience is quite clear that employment of physicians, which was the way the system had existed for decades when I arrived there in 1994 and I was providing very fragmented care, we introduced some functionalities after which the quality, efficiency, and satisfaction with that care had dramatically improved. So I think it does provide important experiential information in this regard.
Perhaps the one difference of note there is that during my tenure, I tried to increase the amount of care that was provided by independent or private practitioners working with the VA, and it took me two years and literally an act of Congress to allow that to be done. And, you know, the -- that was certainly a model of virtual integration that we pursued during my tenure.
Q. Now, I'm not sure that answers my question, because my question was: Has anybody done a study -- and I

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think the answer is no, because this is counterfactual -- but has anybody done a study, like you suggested to me in your deposition, on Kaiser, taking all the employed physicians, making them independent, and seeing what would happen with a system that had the same functionalities as the VHA?
A. No. That study has not been done.
Q. Right. And that's the reason you gave me that the empirical literature is still out on the question of whether employment is an important factor in developing clinically integrated systems; correct?
A. Well, I think when we were having that conversation, it related to Kaiser Permanente, and the point that was being made there was Kaiser started off in a prepaid employment model. That's how they continued, and we -- we can't disengage the role of employment from the other functionalities in that system.
Q. And just for the record, the VHA is still overwhelmingly made up of employed physicians; correct?
A. It is a federal government agency that employs most of its caregivers.
Q. And I'd like to go back to a slide that goes to this point. It's the -- your demonstratives.
MR. KEITH: Do you have those, Mr. Charles?
BY MR. KEITH:

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Q. And it's the set of slides that discussed the three articles.
THE COURT: Let me just note for the record the demonstrative used by Mr. Greene in his examination was apparently Exhibit 3131; is that correct?
MR. KEITH: That's correct.
MR. GREENE: Yes, Your Honor. 3131.
THE COURT: All right.
BY MR. KEITH:
Q. And let's see. So let's go to -- a page that is escaping me -- 13.
Now, I was very interested in this slide because, as far as I can tell, the first two essentially, say, IDSs, integrated delivery systems, result in higher quality, lower cost care.
Am I missing something there?
A. You are reporting part of what it says.
Q. Okay. So both of those basically stand for the proposition that integrated delivery systems are associated with higher quality care and associated maybe more weakly with lower cost care; correct?
A. Right. As I testified earlier today that integrated delivery system in all of their various sizes and shapes and flavors are in the aggregate associated with providing higher quality care.

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Q. So let's go to McWilliams, which is 5050. Do you recognize this article?
A. I do.
Q. And is this the McWilliams article that you cite on Exhibit -- your demonstratives at page 13?
A. It appears to be.
Q. And you summarize this article as having concluded that independent physician groups provided higher quality, lower cost care compared to employed physician groups; correct?
A. I believe that's correct.
Q. Well, let's -- let's take a look. If you turn to page E, as in echo, 2, under Methods and Study Population and Data Sources, you'll see written there, quote, "We analyzed 2009 Medicare claims for a random 20 percent sample of a very large number of traditional fee-for-service Medicare beneficiaries who are continuously enrolled in parts A and B and received at least one primary care service during the year."
So if I understand this correctly, this was a study that was done on fee-for-service Medicare patients; correct?
A. That was who they looked to for the study population.
Q. Okay. And let's see what McWilliams says about the applicability of the results of the analysis to

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risk-based scenarios.
MR. GREENE: Your Honor, if I may, I'm not sure Dr. Kizer actually has the article before him.
MR. KEITH: Oh, I'm sorry. Absolutely, we should. There is a notebook we have that has these materials in them. Thanks for the reminder.
THE WITNESS: And, Mr. Keith, would you be so kind as to direct me to the right --
MR. KEITH: Sure. It's 5050 on the tab.
THE WITNESS: I have it.
BY MR. KEITH:
Q. Great. And we were just looking at page E, as in echo, 2. And now I -- and we established this is a study done on fee-for-service Medicare.
So let's go find what McWilliams says about the applicability of the study to risk-based contracts. If you turn to E, echo, 7, in the last paragraph on that page, the right column, you will see written there --
A. Would you explain to me what "E, echo, 7" means.
Q. Oh, it's the page number; I apologize. It's paginated somewhat strangely in the copy that I have. But each number is proceeded by E.
A. Okay. I think I see it.
Q. So you'll see written there the following: "Thus, our findings provide no basis for predicting whether

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hospital-based groups might achieve greater or lesser savings as risk-bearing ACOs than independent groups."
Do you see that?
A. I don't, but I will take your word that you're reading it correctly.
Q. It's highlighted on your screen. I don't know; you may be looking at the paper copy.
A. I was looking at the text; I'm sorry.
Q. Okay.
A. Now I'm looking at the screen.
Q. And by that you understand that McWilliams actually disclaimed the conclusion that you have included in your chart; that is, hospital-based groups perform less well than independent groups when the circumstances are risk-bearing contracts; correct?
A. I read what you're saying. If you go back to the "findings" section at the beginning of the article, because that's just easier to identify.
Q. I see that. It's on E1.
A. Right. And I believe it says there that, compared with smaller groups, larger hospital-based groups had higher total per beneficiary spending in 2009, higher 30-day readmission rates, and similar performance on four or five process measures of quality, which is --
Q. And we -- I'm sorry.

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A. And what I believe I testified to was that these groups were -- didn't show a quality advantage or -- and they actually had an economic disadvantage.
Q. And now we know from reading the rest of the article that, in fact, that conclusion applied under fee-for-service Medicare and was expressly disclaimed when the circumstances were risk-based contracts; correct?
A. Well, what this says here is that the -- the study doesn't allow one to predict from these findings whether they might or might not achieve greater or lesser savings.
Q. Right. And that's not exactly consistent with your conclusion as in the chart that you provided the court that, without caveat, hospital-based physicians do less well than independent groups; right?
A. I'm sorry. Would you provide me a copy of what was on the reference slide?
Q. Well, I tell you what. Let's move to another question.
Now, also on page E7, the second paragraph under "discussion," which is on the left-hand side, the first two sentences basically explain that large hospital-based groups are associated with higher costs and not better care and, essentially, the conclusion that you described to the court.
Now let's read that last sentence of that paragraph: "These findings were explained almost entirely by the

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specialty orientation of groups, as a strong primary care orientation is associated with substantially lower spending, fewer readmissions, and better quality of diabetes care among hospital-based groups."

Do you see that?

A. Yes. You've read it correctly.

Q. And that's not a caveat you included on your demonstrative, I take it?

A. No. There were many things I didn't include.

Q. Okay. Now, you'll concede that the Saltzer transaction involves a primarily primary care -- well, that Saltzer is a group that has a primary care orientation; correct?

A. That is my understanding, yes.

Q. And so it would fall within the caveat that's highlighted on your screen that I read into the record that the findings that you cited to the court are explained entirely by the fact that specialty groups have less good scores, whereas the primary care groups that are hospital-based actually do relatively better; correct?

A. If I understand what you're asking, in this particular study, with the data that they looked at, they found that a greater primary care orientation was equated with or resulted in a lower cost and higher quality.

Q. And you don't know whether, overall, St. Luke's

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clinic has a primary care or specialty orientation, do you?

A. You said St. Luke's clinic.

Q. That's right. The St. Luke's employed or PSA physicians. You don't know one way or the other whether that group as a whole, considered as a whole, has a primary care or specialty orientation, do you?

A. I don't know that for sure.

Q. Now, let's see. Let's go to E7. We're still under "discussion," the third paragraph down. And there is a sentence there that reads: "These findings suggest that healthcare provider consolidation in a largely fee-for-service payment environment has been associated with slightly lower spending and modest gains in quality of care when centered on primary care but not when centered on specialty care."

Do you see that?

A. I do.

Q. And do you have any reason to dispute that finding in the study?

A. I don't.

Q. Let's do one more part of this -- this article. If you go to -- on the same page, the first paragraph in the right-hand column, these -- these are, generally speaking, the policy imperatives that McWilliams derives from the study.

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And the second sentence of that paragraph reads, quote, "Second, continued consolidation of specialists may contribute to higher Medicare spending in fee-for-service environments as suggested by prior research, whereas efforts to strengthen primary care may be associated with lower spending."

Do you see that?

A. I do.

Q. And you don't have any reason to dispute that finding, do you?

A. Again, I don't dispute that.

Q. And you would agree with me that the addition of the Saltzer physicians into St. Luke's clinic's employed and PSA'd group of physicians has the effect of strengthening their primary care; correct?

A. I believe, if I understood what you're asking, that that would be correct.

Q. And just on a slightly unrelated note, you suggested earlier that employment wasn't sufficient to generate clinical integration, and one of the reasons was just employing somebody doesn't mean they're going to have the same values or drive in the same direction that the system is; correct?

A. That is correct.

Q. And -- but you're not suggesting to the court

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that, in fact, the Saltzer physicians aren't on board and engaged in trying to make St. Luke's Clinic the best possible clinic it can be in the delivery of integrated care, are you?

A. I haven't suggested to the court one way or the other.

Q. You just don't know; right?

A. I do not know.

Q. Now, in your testimony, you identified some alternatives to the particular transaction at issue here. And --

A. Are we done with the --

Q. Oh, you keep it; we may come back.

So you identified a few alternatives to the court that you thought were options for Saltzer should the transaction be unwound.

Do you remember me asking you at your deposition the follow- -- what, if anything, Saltzer needed to do if the transaction is unwound in order to be in a position to deliver the kind of integrated care that you say we need in our healthcare system?

A. And I believe I responded to you that I had not been asked to opine on that topic.

Q. Right. You were not asked to opine on the topic of what Saltzer could or should do if unwound so that it

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would be in a position to deliver integrated care; correct?
A. That is correct. That was not what I was asked to develop opinions on.
Q. And so we actually went a little bit round and round in your deposition, because I wanted you to give me a specific contract or some construct that you would recommend as an alternative to the transaction at issue here.
Do you recall that?
A. I recall that we went round and round on quite a few things.
Q. Well, that was one of them; correct?
A. I believe you're correct.
Q. And at the end of the day, you said, "I'm not here to prejudge what Saltzer should do or could do in terms of its contracting"; correct?
A. That seems to capture the spirit of what I said. I don't recall using those words, but --
Q. But would that be a fair answer to my -- to that question; that is, why don't you provide me a specific contract idea that you think Saltzer would pursue or should pursue if unwound? Would your answer be, "I'm not in a position to do that"?
A. Again, I was not asked to render an opinion in that regard.
Q. Nor were you asked to render an opinion on whether

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St. Luke's is or is not capable of entering risk-based contracts; correct?
A. I don't recall that that was a specific deliverable.
Q. Well, and you told me in the deposition that, in fact, it was not a deliverable that you understood was part of your -- your work; correct?
A. I think we are saying the same thing.
Q. Okay. Well, as long as they're the same thing.
And so you're not really in a position, since you don't know whether St. Luke's is capable of taking on risk contracts, to opine on whether if St. Luke's is divested from St. -- if Saltzer is divested from St. Luke's, St. Luke's will, you know, have any -- that will have any impact on St. Luke's ability to enter risk-based contracts; correct?
A. I think I was not asked to opine on that, so I haven't rendered a formal opinion in that regard.
Q. And so you're not in a position to say one way or another whether the addition of the Saltzer Medical Group to St. Luke's Clinic aids St. Luke's in being able to enter into risk-based contracts; correct?
A. Again, that was not something that I was specifically asked to opine on.
Q. Now, let's look at page 27 of Exhibit 3131. This

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is your demonstrative. These are what you indicated to the court would be sort of options for Saltzer.
Now, given the testimony that we've just gone through that you're not giving an opinion on what Saltzer should do and you're not giving an opinion on what St. Luke's is capable of doing in terms of risk-based contracting, do I correctly understand these as simply -- these are just sort of high-level of examples of might potentially be possible? Is that fair?
A. This demonstrative was intended to provide some examples of how independents might be incentivized to provide quality care.
Q. But you're not, you just told me, opining on what Saltzer could or should do to deliver integrated care, including doing any of these things; right?
A. Again, I'm not sure if we're talking at each other or not, but as I've said, I wasn't asked to opine on that, and this wasn't offered as a specific opinion in that regard.
Q. And am I correct in understanding -- well, do you have the understanding that each of the examples you've listed here, to the extent it's actually available to Saltzer Medical Group, would be in the form of some kind of gain-sharing contract?
A. That would be one option that we talked

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specifically about the Medicare Shared Savings Program as an example of that.
Q. And are you aware of whether Saint Alphonsus Health Alliance is -- has any contracts under which Saltzer would be subject to downside risk?
A. I'm not aware of any.
Q. Right. And are you -- do you know as of today whether Saint Al's Health Alliance provides integrated care?
A. Again, I wasn't asked to assess Saint Al's Health Alliance and their performance or whether they are or are not providing integrated care.
Q. And I take it you're not going to stake your reputation by giving the judge a date certain when Saint Al's Health Alliance will be delivering integrated care; correct?
A. Well, I will just go back to what I just said. I wasn't asked to develop an opinion in that regard, so I'm not going to offer an opinion in that regard.
Q. And the same is true for Select Medical Network; right? You're not in a position to opine on whether they, the Select Medical Network, currently or at some certain time in the future will provide integrated care; correct?
A. What I just said before would follow, I believe.
Q. Now, you're familiar with the Geisinger model, are you not?

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A. I am familiar with it. I'm not quite sure what you mean by "familiar," but, obviously, I'm aware of it.

Q. Well, you're aware that they articulate their approach to integrated care as relying on a core of physicians?

A. I understand that they utilize both employed and independent physicians, and they like to test out things among their employed physicians first.

Q. And have you analyzed where Geisinger places its employed physicians versus its independent physicians in terms of the footprint of that system?

A. I have not done that analysis.

Q. No. And do you have any reason to dispute Dr. Enthoven's testimony that an efficient primary care provider within an integrated delivery system can carry roughly 1500 patients, a panel of 1500 patients?

A. Well, it, in the abstract, would be accurate, understanding that it depends entirely on the nature of the conditions of those patients. And if they had complex serious problems, then that might be way too many.

Q. And could be less, could be more, but that's probably a good rough gauge, you think?

A. It's in the ballpark, generally.

Q. Okay. And you testified that there is a nucleus of St. Luke's employed physicians in Nampa; correct?

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A. I understand that there are about eight employed physicians out there.

Q. Well, you called them a nucleus. Are you going to -- is that not a word you would use?

A. Not -- if you want to use "nucleus," that's fine.

Q. And it's seven, actually, not eight.

But so seven primary care physicians times 1500 is how many patients those physicians could care for under an integrated delivery system model?

A. Are you asking me to do the math? That's 12,500 patients.

Q. And how big is the population of Nampa?

A. I don't know exactly what the population of Nampa is.

Q. And how about the population of Canyon County?

A. Again, I don't have those figures immediately at hand.

Q. And do you know how many patient -- individual patients seek their care in Nampa, whether they live there or not?

A. Again, I don't have that information.

Q. You don't know how many patients come from Canyon County to use St. Luke's facilities in Ada County; correct?

A. Again, that's not something I was asked to

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investigate.

Q. So in terms of judging whether seven physicians sitting in Nampa is an adequate nucleus, you're not in a position to -- to figure out, as a percentage of the population that St. Luke's would like to serve, how many those seven could actually treat; correct?

A. I'm not sure that we are talking about the same thing here. The core nucleus theory implies that a certain number develop something to see whether it works. It's not talking about covering the entire population.

Q. But you would agree with me that you don't have any means of knowing what portion of the total population intended to be served in the integrated delivery system, those seven physicians could serve; correct?

A. I don't have that information.

MR. KEITH: No further questions.

THE COURT: Redirect.

MR. GREENE: Thank you, Your Honor.

Your Honor, before I proceed to redirect, we do have a time question. By our calculation, it is the case that, assuming that defendants actually want Your Honor to review the video deposition portions that they have indicated, assuming that is a correct assumption, they have run out of time. So we are not quite clear how best to proceed here in terms of our own planning.

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THE COURT: Well, and -- Mr. Keith.

MR. KEITH: Your Honor, we did the best we could, but I believe we probably are close to the end of our time.

THE COURT: What are we talking about?

MR. KEITH: I think --

MS. DUKE: Your Honor, the calculations are there is 35 minutes of time in the queue to be played by video that the defendants have designated, and they are six minutes in the hole now if you don't assume playing any video. So it's substantial.

And, obviously, we, as the plaintiffs, have been under the same parameters and -- and it's close for us, but we're going to make it. So I think --

THE COURT: Well, let's carry on with the cross-examination here. I assume there will be no redirect or recross. And then we'll see where we are with the next witness and then work out the arrangements.

I try -- somehow the concept of a steel hand with a velvet glove comes to mind as trying to work that out, and we'll just have to see how that works out.

All right. Let's go ahead and proceed. Mr. Greene.

MR. GREENE: Thank you, Your Honor. If I may ask Mr. Keith for a favor and have him ask his person to bring up the slides that you guys used. Page 1 of the demonstrative.

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THE WITNESS: Perhaps, in the -- if I might volunteer, if that's -- I just want to correct the math that I cited before.

THE COURT: Okay. Go ahead.

THE WITNESS: 10,500, not 12,500. I just -- I misspoke.

MR. GREENE: Thank you. Thank you for your courtesy; I appreciate it.

REDIRECT EXAMINATION

BY MR. GREENE:

Q. Dr. Kizer, obviously, Mr. Keith took you through this, but let me just very quickly go through. Does it require an employed physician to have a common vision of healthcare delivery?

A. No.

Q. Does it have -- do you need a -- an employed set of physicians for shared and widely understood clinical objectives and goals?

A. No.

Q. Does it require employed physicians to have information management tools and other infrastructure to monitor, analyze, and affect processes and quality of care and clinical outcomes?

A. No.

Q. Does it require employed physicians to have

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policies and procedures for coordination -- coordinating care across conditions, providers, settings, and time?

A. No.

Q. Does it require an employed set of physicians to have a performance management system that consistently measures and monitors clinical performance by use of standard --

MR. GREENE: Would you flip the next one?

BY MR. GREENE:

Q. -- standardized performance measures?

A. No.

Q. Does it require employed physicians to have a patient-centric and population health focus?

A. No.

Q. Does it require employed physicians to share financial risks and rewards for clinical outcomes?

A. No.

Q. Does it require employed physicians to have improved clinical efficacy?

A. No.

MR. GREENE: Would you move to the next page, please?

BY MR. GREENE:

Q. Does it require employed physicians to have utilization and demand management programs?

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A. No.

Q. Does it require employed physicians to have common patient identifiers?

A. No.

Q. Does it require employed physicians to have an EMR?

A. No.

Q. Does it require employed physicians to have clinical physician support and other information management tools?

A. No.

Q. Does it require employed physicians to have clinical guidelines and care pathways?

A. No, sir.

Q. With respect to the next slide --

MR. GREENE: If you'd turn to that.

BY MR. GREENE:

Q. -- does it require employed physicians to have performance measurement and other continuous quality improvement activities?

A. No.

Q. Does it require employed physicians to have case management and disease management programs?

A. Again, no.

Q. And do you need employed physicians to have

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clinical service lines?

A. No.

Q. Is it required to have employed physicians to have disease registries?

A. Again, no, sir.

MR. GREENE: I have no further questions, Your Honor, at this time.

THE COURT: Mr. Keith. We operate by hand signals, so the time on the clock doesn't start.

MR. KEITH: It takes less time.

THE COURT: I understand.

All right. You may step down.

THE WITNESS: Thank you, sir.

MS. DUKE: So, Your Honor, the last live witness is Dr. Polk, so we'll call him in a moment. We also are going to be submitting to the court two video depositions, Dr. Huerd and Dr. Seppi. You have already received part of Dr. Seppi during our original submission, and now we'll be playing additional Dr. Seppi that we'll submit to you in chambers.

THE COURT: All right.

MS. DUKE: But just to get us all kind of regrouped and in the same frame of mind with respect to this time issue, the defendants at this point have 29 minutes remaining.

THE COURT: The defendants have 29?
MS. DUKE: Correct. But that doesn't factor in --
THE COURT: The 35 minutes.
MS. DUKE: -- the video that they have told us they were going to submit to you. So maybe they're intending not to submit that video to you any longer.
THE COURT: Well, I think they'll -- they can make a decision, typically --
MS. DUKE: Okay. I just wanted to make sure.
THE COURT: -- on deciding how and whether to cross the final witness.
MS. DUKE: Great. Thank you, Your Honor.
THE COURT: And we'll figure out where we are then.
Mr. Ettinger, what's your estimation with -- is it Dr. Polk, I think?
MR. ETTINGER: Yes, Your Honor.
THE COURT: What's your estimation of direct?
MR. ETTINGER: Around 45 minutes, Your Honor.
THE COURT: I don't think we can make it without another break. Perhaps we need to take -- let's try to take a five-minute break just long enough to stretch our legs, maybe ten minutes tops, and then we'll come back and finish up with Dr. Polk. Counsel can then discuss how they -- where they want to go from there.

All right. Let's take a short ten-minute recess.
(Recess.)
****** COURTROOM REMAINS OPEN TO THE PUBLIC ******
THE COURT: Counsel, after Mr. Metcalf and I discussed and he came in to report to you, I started to somewhat weaken in my resolve. I'm going to see where we are. I may give a few minutes here, but let's see where we are at the end of Dr. Polk's testimony.
Dr. Polk is being summoned. There you are. Sir, if you would step before the clerk and be sworn.
JAMES ROBERT POLK,
having been first duly sworn to tell the whole truth, testified as follows:
THE CLERK: Please state your complete name and spell your name for the record.
THE WITNESS: James Robert Polk, P-O-L-K.
THE COURT: You may inquire.
MR. ETTINGER: Thank you, Your Honor.
DIRECT EXAMINATION
BY MR. ETTINGER:
Q. Dr. Polk, what is your current position?
A. I'm the chief quality officer and vice president for patient safety and quality for the Saint Alphonsus Health System.
Q. So what are your general areas of responsibility?

A. I'm responsible for quality and safety throughout the four hospitals and the medical group and the Saint Alphonsus Health Alliance.
Q. And how long have you had responsibility for patient safety and quality with regard to Saint Alphonsus Regional Medical Center?
A. Since 1999.
Q. And what position did you have in 1999?
A. I was chief medical officer.
Q. And how long have you had responsibility for patient safety and quality with regard to Saint Alphonsus Health System?
A. Since late 2010.
Q. And what happened in late 2010?
A. I was then appointed as the chief quality officer for the system.
Q. And did your responsibilities from that point forward include SAMG?
A. Yes, it did.
Q. And did they include quality and safety with regard to physician activity in the hospitals?
A. Yes, it did.
Q. And how long have you had responsibilities for patient safety and quality with respect to the Alliance?
A. Since it was formed.

Q. What kinds of physicians are in the Alliance, generally speaking?
A. So the Alliance is composed of 1200 to maybe 1300 different providers -- family physicians, primary care physicians, specialists, and some nurse practitioners and physician assistants.
Q. How does that break out roughly between independent and employed physicians?
A. It's about 75 percent independent and 25 percent employed.
Q. Dr. Polk, as you know, one of the topics I'm going to talk about today is Explorys. What are your responsibilities with respect to Explorys?
A. I'm the accountable executive for Explorys.
Q. What does that mean to be the accountable executive for Explorys?
A. It means I'm responsible for the implementation and setting it up, making sure that goes well. And if it doesn't go well, then I'm responsible.
Q. What is the Quality Informatics Work Group?
A. So the Quality Informatics Work Group is a group composed of hospital, medical group, and Alliance quality and safety people.
Q. And what -- what's your role with regard to that work group?

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A. I chair that group.
Q. And what's the -- what are the general responsibilities of that work group?
A. Well, we meet and preview hospital and ambulatory quality metrics and initiatives so we can gain some consensus about what's happening across the system. And we do approve those metrics and initiatives.
Q. By the way, just to make sure that all the jargon is clear, what do you mean by ambulatory?
A. I mean outpatient through clinic settings.
Q. And by "clinic," you mean physicians' clinic?
A. Yes, sir.
Q. In your experience at Saint Alphonsus -- let me back up. I missed some of your background. Before you were chief medical officer at Saint Alphonsus, what did you do?
A. I was in private practice in rheumatology in Boise.
Q. And for about how long?
A. Sixteen years.
Q. In your experience at Saint Alphonsus, is an employment or professional services agreement relationship between the hospital and physicians at all necessary for physicians and hospitals to work together to improve care?
A. No, it's not.
Q. At Saint Alphonsus, have you had experience

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working with independents on improving care?
A. Yes.
Q. Let me ask you about a few examples. What was the 100,000 Lives Campaign?
A. That was a campaign that was initiated by Institute for Healthcare Improvement back in 2004. It was a nationwide campaign based upon certain evidence-based practices that were known to save lives in hospitals.
Q. And were there bundles of care involved in that program?
A. Yes. It was characterized by six different bundles, such as preventing central line infections, antibiotics within one hour of cut time, ventilator-associated pneumonia, setting up rapid response teams. And through these six different initiatives, it was felt by the leadership at IHI, Don Berwick, that if they were instituted, lives would be saved across the country. And they thought 100,000 lives would be the target.
Q. About how many hospitals across the country participated in this program?
A. Over 3,000.
Q. Did Saint Al's participate?
A. Yes.
Q. Were the physicians -- were physicians involved in the program?

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A. Absolutely.
Q. Were they involved in approving the bundles as well as implementing them?
A. Well, they not only had to improve them, they had to come up with ways, working with hospital staff, on how to implement them.
Q. So what was the role of independent physicians at Saint Alphonsus in working on these bundles of care?
A. Well, at that time they were all independents who were working on those initiatives, and they were involved in improving and implementing them.
Q. What was achieved by Saint Alphonsus in terms of its participation in the 100,000 Lives Campaign?
A. We calculated, using the IHI formula, that we saved 62 lives through that initiative.
Q. Let me ask you about another program, the SCIP program. What was that?
A. It stands for the Surgical Care Improvement Project. Saint Alphonsus was the only hospital in Idaho invited to participate in a Medicare collaborative back in 2002 when it started. There had been a lot of evidence, for example, that if you do certain things in the perioperative period, that you can make the outcomes better.
So we took a team back -- myself, two other physicians, some infection prevention staff. That was the

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core team to get started.
Q. You said you took them back?
A. To Washington, D.C., for the collaborative meetings.
Q. And that team you took back, how did those doctors break out in terms of employed versus independent physicians?
A. One was Don Fox, who is an independent anesthesiologist. The other one was Jack Bishop, who is an orthopedic surgeon.
Q. Is Dr. Bishop employed or independent?
A. Independent.
Q. And so what did these independent doctors do as part of this effort?
A. Well, we went to the meetings. We looked at the data, looked at the elements of the program, agreed that we needed to implement them. And then we came back and came up with action plans and implementation plans.
Q. And what was achieved as a result of that effort?
A. Well, our baseline rate -- given that you should be at 100 percent, our baseline rate was probably about 30 percent.
So the team had to work with physicians, all types of surgeons -- general surgeons, orthopedic surgeons, neurosurgeons, gynecologists -- because there are many, many

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procedures that are affected by these metrics, and convince them that this is the way to change and we need to be doing better.

And then principally that was around antibiotics within one hour of cut time.

Q. And did you achieve any particular metric with regard to antibiotics within one hour of cut time?

A. Yes. We improved from our baseline that I mentioned, about 25, 30 percent, to 98 to 100 percent. And it's still a metric that is pursued today.

Q. And by the way, the phrase "antibiotics within one hour of cut time," why don't you just explain in slightly simpler English what that is.

A. Okay. The research, the evidence at that time had shown that if you gave antibiotics before surgery, you would lower the chances of getting a surgical site infection or a wound infection for the patient postoperatively. The question was always: How reliable are we as a country in doing that for every surgical case for which it applies, and what antibiotics are we actually going to use? And the other question was: How long do you continue that antibiotic postoperatively?

So through that collaborative, that national collaborative, we agreed that -- on what the right antibiotics were, that they should be discontinued at 24

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hours, and that they should be given within one hour of cut time, meaning one hour -- in the hour prior to the incision being made.

Q. In terms of the quality initiatives that you have worked on since you have been either -- since you have been working for Saint Alphonsus, have you seen any resistance from physicians to quality initiatives and efforts to institute evidence-based medicine?

A. Most physicians want to do the right thing; there is no doubt about it. They went into healthcare because they want to see good outcomes in their patients that they care for. So I think that's been pretty much the theme. There is always varying degrees of resistance, but if you approach it in the right manner, you can usually overcome that.

Q. So in terms of the resistance that you have seen, has that been present for -- among some SAMG doctors?

A. Yes.

Q. Has it been present among some independent doctors?

A. Yes.

Q. Have you seen any difference in the degree of resistance as between SAMG and independent doctors?

A. No, sir.

Q. You mentioned what you need to do to overcome

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resistance and get physician buy-in. Can you explain a little bit more if there is a process that you utilize for that.

A. Right. It takes three major elements. One is you have to create the burning platform for change, and usually that's around either data or some other information that creates a sense of dissatisfaction or it makes a gap apparent between care that's existing today and the evidence-based care or the best care.

Then you have to get agreement on the vision. So the vision of where we want to be in our performance, say, one to two years from now, that needs to be a shared vision. And for most physicians, they always -- when asked pointedly, "Don't you always want to do what's right for the patient?" they will say "Yes."

And then the third thing is you have to have some idea of what are the changes that we can make to make an improvement. You have to have some idea of what those initial steps are.

When you get those three lined up, people are ready usually at that point to get down and work.

Q. Is that process any different in your experience for independents versus employed physicians?

A. No, it is not.

Q. And why not?

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A. Physicians are highly trained professionals and they are really experts. They have had long education, devote long hours, take their work very seriously. You don't want to be in a position where you're ordering them around or trying to order them around. Because in the long run, that means they haven't bought into the vision, they don't agree with what you're trying to do, and they won't take the accountability and responsibility for the outcomes.

So it's very important to respect them through the process and get them to buy into the vision so that they will make sure that everything happens appropriately.

Q. Now, the independent physicians who were involved in the SCIP program or the 100,000 Lives program or other evidence-based medicine programs that Saint Alphonsus has engaged in, have they been paid for those efforts?

A. No.

Q. Are there circumstances, though, where Saint Alphonsus pays physicians to take leadership roles on quality issues?

A. Yes.

Q. And is there some category, some job description that fits that situation?

A. Well, we call them "medical directors" or "service line leaders."

Q. So when you have medical directors or service line

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leaders, do they tend to be full-time employees of Saint Alphonsus or SAMG or don't they?

A. They are almost never full-time.

Q. So what do you -- how do you pay them and what do you pay them?

A. So we pay them an hourly rate and pay them -- compensate them according to that rate.

Q. Is that rate simply for the efforts they make in terms of quality leadership?

A. Yes, and medical direction.

Q. Are they also paid for patient care by Saint Alphonsus or not?

A. No.

Q. Why not?

A. It's just not part of the contract. If we have an independent physician we want to contract with for medical direction, we pay hourly for that, and their independent practice is -- covers their patient care income.

Q. Just so I'm clear, in those circumstances, you pay the doctor to work for you as a service line director, and the rest of the time the doctor treats patients as an independent doctor; is that right?

A. Yes. For the most part, yes.

Q. Let's take one example. Who is Dr. Julie Foote?

A. Dr. Foote is an endocrinologist. She is really a

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very good leader in healthcare.

Q. Is she a service line director for Saint Alphonsus?

A. We do pay her for medical direction for our diabetes program.

Q. Does she treat patients?

A. Yes.

Q. In patient care, does she work for Saint Alphonsus or is she an independent?

A. She is an independent.

Q. How is she paid as a service line director?

A. Hourly.

Q. How long has she been the service line director for the diabetes program?

A. It's probably three to four years now.

Q. Has that been a successful or unsuccessful program in your opinion?

A. It's been very successful.

Q. Can you briefly describe some of its achievements.

A. Yes. Dr. Foote took some initiative and, as an endocrinologist, knows a lot about treating diabetes. She realized that on the inpatient side at that time -- and really on the outpatient side -- treatment of diabetes was changing across the country, and we needed to fine-tune it and make it better.

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So she initially looked at the hospital, and it was a multidisciplinary team, to improve the care. It involved a lot of order sets, putting in evidence-based practices to make sure that diabetes-related medications were done appropriately, that dietary changes had to be made in the program.

So she spent a lot of time on it to develop it and did an outstanding job. So, as a result, we ended up being the only hospital in the state of Idaho certified in advanced inpatient diabetes care by the Joint Commission.

We also have achieved an outpatient certification from the American Diabetes Education Association.

Q. What is the Joint Commission?

A. The Joint Commission is probably the premiere regulatory body in the country and does a lot of quality and safety work.

Q. About how many independent physicians are service line directors at Saint Alphonsus?

A. Right now in the Saint Alphonsus Health System, that number is 20.

Q. So let me ask you about some quality issues relating to physicians, not necessarily relating to the hospital.

Will the federal government be providing financial incentives for physicians to improve their quality?

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A. Absolutely.

Q. And how will that affect Saint Alphonsus?

A. It will affect all of the physicians within the Saint Alphonsus Health System.

Q. And is that effort called the Value-Based Modifier Program?

A. It is. That is the program that recently announced that it's coming down the pike that will affect primary care physicians principally in terms of their reimbursement by modifying their payment based upon cost and quality of their Medicare-attributed beneficiaries.

Q. So how is that going to work generally? Are there going to be quality metrics applied?

A. There 25 quality metrics and about 5 cost metrics that go into that equation. And if you -- right now it applies only to medical groups of greater than 100 providers and a tax ID number.

Q. So is there going to come a time when it applies to smaller groups?

A. The 100-member group, it will start October 1st of 2014. For federal fiscal year '15, it will apply to groups of 25 providers or more. And we have been told that by January 1st of 2017, it will apply to all physicians in the country.

Q. So what are a couple examples of the quality

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metrics that are going to be applied under the value-based modifier program?
A. The 25 are quite extensive. They not only include diabetes, but also osteoporosis, hypertension, cholesterol management, readmissions, mental health, use of certain high-risk drugs in the elderly. It's quite an extensive program.
Q. And so what will happen if a doctor doesn't hit the targets, the quality targets and cost targets?
A. If a physician's performance is in the high-quality, low-cost quadrant, that physician may get initially a 2 percent boost in their payment, in their Part B payments. If they have low quality and high cost, they could get a 1 percent penalty to their Part B payments.
Q. So will this affect any just employed physicians or also independent physicians?
A. It will affect all physicians.
Q. Now, let me ask you about some other quality metric issues. Does -- has Saint Alphonsus had programs where it has paid independent physicians based on quality metrics?
A. Yes.
Q. Is the term "pay for performance" used?
A. Yes.
Q. What does that mean?

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A. It means that if a physician or group of physicians hits certain quality, efficiency-type targets, they will get paid a bonus.
Q. And in what areas has Saint Al's had pay-for-performance agreements with independent physicians?
A. Orthopedics, pulmonology, emergency room physicians, anesthesia. And I'm sure there are a couple more I have forgotten.
Q. So when did Saint Alphonsus first adopt pay-for-performance agreements with independent physicians based on quality?
A. I would say back when the 100,000 Lives Campaign started in 2004, because it focused on ventilator-associated pneumonia. So the pulmonologists were probably one of the first groups, and I think the emergency room physicians were another earlier adopter back in '04, '05.
Q. Since you mentioned orthopedics as well, let's talk about that example in a little bit more detail. How does pay-for-performance work in the orthopedics area at Saint Al's?
A. So in orthopedics, we have an orthopedic comanagement group which is comprised of six independent physicians and three employed physicians. And they are being paid on a bonus in relationship to patient satisfaction, cost and quality metrics.

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Q. So you said cost metrics. What's an example of cost metric that applies to the orthopedic surgeons?
A. So, for example, average hardware cost per case, average cement cost per case, and they lump all the other costs into average cost per case.
Q. What's an example of a quality metric that applies to the orthopedic surgeons?
A. They have selected three of the SCIP measures, two that have to do with blood clots, preventing blood clots, and one that has to do with your urinary catheter removal on post-op day one or two.
Q. Have the quality metrics generally been met by the orthopedic surgeons?
A. They are hitting the quality metrics, and they are good targets. They are not easy targets.
Q. Have the cost metrics generally been met by the orthopedic surgeons?
A. They are not hitting the cost targets yet.
Q. So what's the consequences to them of not hitting the cost targets?
A. They won't get their bonus payment.
Q. Have quality metrics been approved by the Alliance?
A. Yes.
Q. And are these isolated individual metrics, or are

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they organized in some way?
A. Pretty much across the country, you can -- as integrated systems start approaching this, they are looking at diabetes metrics, dyslipidemia or cholesterol metrics, hypertension metrics. And so some of those same ones are in the initial Alliance set of metrics.
Q. Are any of them currently being calculated for Alliance members?
A. No.
Q. And when do you expect that will begin?
A. Probably December or January.
Q. Which Alliance members will those quality metrics apply to?
A. We're doing a rollout, obviously, and some pilot work and user validation testing as we speak. The December-January time frame will be a few of the Saint Alphonsus Medical Group sites and then Primary Health Medical Group.
Q. Will it include -- Primary Health, of course, is an independent group.
A. Yes.
Q. So will these apply to independents as well as employed doctors?
A. Yes.
Q. So let's talk about data analytics tools. Has

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Saint Alphonsus used data analytics tools?
A. Yes.
Q. What is MedVentive?
A. MedVentive is a registry and data analytic tool that's being used in the Saint Alphonsus Medical Group.
Q. When did Saint Alphonsus adopt MedVentive?
A. It was in 2012, about the middle of the year.
Q. And does MedVentive apply, then, only to employed doctors?
A. No. We had planned to use it within the Alliance.
Q. But have you, in fact, used it within the Alliance?
A. No, we have not.
Q. And have you personally reviewed data from MedVentive?
A. I have.
Q. What is Crimson?
A. Crimson is a data analytics tool that focuses on inpatient hospital care and outpatient hospital care.
Q. And do you personally review data from Crimson?
A. Yes.
Q. Which patients -- so Crimson applies to hospital care. For which physicians is Crimson used? Is it used just for employed doctors, or does it go beyond that?
A. It's all physicians on the medical staff, whether

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they are employed or independent.
Q. And when did Saint Alphonsus adopt the Crimson data analytics tool?
A. 2010.
Q. 2010?
A. Yes.
Q. And where does Crimson get the data on independent physicians?
A. Since it's mostly hospital based, it gets it from the hospital systems.
Q. And what is the data analytics tool that is going to be used by the Alliance?
A. Explorys.
Q. We talked a little bit about your role with regard to Explorys. In connection with your role as the accountable executive for Explorys, have you been involved in meetings with Explorys representatives?
A. Yes.
Q. Have you reviewed Explorys demos?
A. Yes.
Q. And what is a demo, just so --
A. A demonstration of how it works.
Q. Have you also reviewed demos for competing systems?
A. Yes.

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Q. And what competing systems?
A. Truven and Humedica.
Q. After reviewing Truven and Humedica and Explorys, which one did you recommend be used?
A. Explorys.
Q. And why was that?
A. It appeared to be easier to use, and in a clinic setting seemed to be easier to use.
Q. And in the course of -- in the course of your review of Explorys, what did you learn about its sources of data as a data analytics tool?
A. It is broad. There are -- sources of data that they can move into Explorys is quite broad.
Q. So on -- does it rely on EMR data, electronic medical records data?
A. It can pull in basically any EMR: Lab data from either within a hospital or a regional lab; it can pull in Idaho Health Data Exchange information; admission discharge, transfer information. It's quite broad in what -- the data that it pulls in.
Q. Does it pull in claims data as well?
A. Yes, from payors and other places.
Q. Is the fact that Explorys can pull in these broad and varied sources of data, is that important to the Alliance or not?

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A. It is important.
Q. And why is that?
A. Well, for population management and even individual patient care, you want to know where the care is being rendered and if it's being rendered appropriately. So it's very important to know what's going on with your patient population.
Q. In particular, the fact that Explorys can draw from many different electronic medical records, is that of importance to the Alliance?
A. Yes, because there are many different electronic medical records that are being used even in the Treasure Valley.
Q. So is the -- is Explorys going to be able to take data from all those different medical records if those physicians are participating?
A. Yes.
Q. And so if the physicians are not all on one medical record, does that create a problem for Explorys?
A. No.
Q. In terms of claims data, where will Explorys be drawing its claims data from?
A. Well, from the payors and perhaps from the practice management systems of the physicians themselves and perhaps from the billing clearinghouses.

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Q. When you say "billing clearinghouses," what is a billing clearinghouse?
A. They function as kind of a pivot point for physicians to send in their claims electronically, and then the billing clearinghouse will process them to the payors.
Q. And so does a billing clearinghouse have data from multiple providers?
A. They can.
Q. You said perhaps. Is this something that hasn't yet been completely determined?
A. We're looking at it in terms of cost and efficiency as to which way we'll go.
Q. What group, medical group, is first going to be tested on Explorys?
A. The first independent group will be Primary Health Medical Group.
Q. So I gather -- let me back up. So Explorys is not yet in place and operating for the Alliance; is that correct?
A. It will be December or January.
Q. And by the way, you know, it's been covered by other witnesses, but just to be clear: What is the Saint Alphonsus Health Alliance?
A. It's a group of providers, 1200 to 1300 providers; 75 percent are independent.

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Q. And is the intention that the Alliance will be contracting with payors?
A. Absolutely.
Q. So you said Primary Health will be tested first. What EMR does Primary Health have?
A. EClinicalWorks.
Q. Okay. And assuming the -- after the Primary Health test is completed, who will next be offered Explorys among the Alliance -- among the Alliance members?
A. It would be other users of eClinicalWorks. And I think -- I think Saltzer is the largest user of eClinicalWorks.
Q. So given that this is -- the Explorys implementation is just beginning, do you have any doubt that this will proceed successfully?
A. It will be successful.
Q. And what do you base that on?
A. Well, Explorys has a very good track record.
Q. So is Saint Al's Explorys's first rodeo?
A. No.
Q. What's Explorys's experience in terms of implementing data analytics tools at providers?
MR. KEITH: Objection, foundation.
MR. ETTINGER: Your Honor, the witness has made extensive review of Explorys.

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THE COURT: Overruled. You may answer.
THE WITNESS: Thank you. Explorys is in 17 integrated networks, 295 hospitals, and has 35 million patient records in it.
BY MR. ETTINGER:
Q. So, Dr. Polk, I would like to take a look first briefly at Crimson and then Explorys and look at some slides that show what kind of information they provide, starting with Crimson.
Your Honor, this is Demonstrative 3071. It's four slides.
THE COURT: Thank you.
BY MR. ETTINGER:
Q. So Crimson, of course, is the system that you've already had for a few years in the hospital; is that right, Dr. Polk?
A. Yes.
Q. Applies to both independent and employed physicians?
A. Yes.
Q. So what is the slide 1 of this group of slides on Crimson? Can you explain what's shown here.
A. Well, these slides show various readmission parameters, mortality rate, and observed expected ratios on readmissions and mortality and complications. It's

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something that any physician would want to know.
Q. So is this a report for a particular physician?
A. Yes, it is.
Q. And I see there is a little black box at the upper left. Is that the blacked-out name of the physician?
A. That's correct.
Q. So does each physician on the Saint Al's medical staff get reports like this for his or her patients?
A. Yes. And they can access it on their own. They all have their own passwords and user names to get into it on their own.
Q. Okay. So this is actual physician data?
A. Yes. This particular physician is a surgeon.
THE COURT: Counsel, is this a Crimson continuation --
THE WITNESS: Continuum of care.
THE COURT: So Crimson is part of Explorys? Is that just --
THE WITNESS: No. It's a different data analytics tool.
THE COURT: Okay. I'm sorry. I thought you were demoing or showing --
MR. ETTINGER: Your Honor, we are first showing Crimson, which is already in place at the hospital.
THE COURT: Okay. Sorry. I probably was just

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making a note and lost something in the -- I think it's now clear. Sorry. Go ahead.
BY MR. ETTINGER:
Q. Just to be clear, Dr. Polk, what's the difference between Crimson and Explorys?
THE COURT: Counsel, I understand now the difference. You don't probably need to go back and replow that. My apologies.
BY MR. ETTINGER:
Q. So if I'm the doctor, Dr. Smith, say, whose report this is, what do I learn from this slide?
A. Well, first of all, the dials are colored. They are colored green, yellow, red. And green is good. It means that that physician is within one-half standard deviation of the compare group.
The other thing the physician can do is change the compare group. The compare group can be physicians within the Saint Alphonsus repertoire, or it can be a national compare group, or it can be the Crimson cohort compare group, which is 500 hospitals.
Q. So looking at the upper left, you see the 2.93 percent and the 5.60 numbers, Dr. Polk?
A. Right.
Q. And what does that refer to?
A. It means that -- and it's green, so it means that

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rate is still within a half a standard deviation of the compare group.
Q. So the 2.93, is that the individual doctor's score?
A. Yes. Yes, it is.
Q. What is the 5.6 percent?
A. That's the seven-day readmission rate for any APR DRG for the compare group.
Q. So this doctor is doing about -- about half the readmissions of the typical doctor?
A. He is doing well. It's still within a half standard deviation of everyone else.
Q. So how would a doctor, looking at slide 1, how would he or she use it in terms of trying to improve his or her practice?
A. Well, this would show me, were I the surgeon, that I don't see much opportunity for improvement looking at this. I have got a really good 30-day readmission rate, observe to expected, and my mortality rate is basically zero.
Q. But if my scores are higher than the benchmark, if the top number is greater than the bottom number, what does that tell me?
A. Well, if the dials change color, they are yellow or red, it means I have an opportunity to improve based upon

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the statistical analysis and the risk adjustment model of the tool.
Q. Why don't we go on to slide 2. What does slide 2 show, Dr. Polk?
A. This is a national comparison of this physician's performance against the Agency for Healthcare Research and Quality Patient Safety Indicators.
Q. So this refers to death rate and low mortality DRGs, for example. What does that mean?
A. Well, you wouldn't want to be known as a physician who had patients die if your DRG was already known nationally to have an odds of mortality of being very low.
Q. So these are all indicators -- these are all bad things that the doctor wants to avoid on this chart; is that right?
A. Yes. Many of them have in the past been called never events. Notice the column in green, which means this physician is doing well.
The tool is very nice, though, in that on the very last metric, postoperative pulmonary embolus or deep venous thrombosis, you see this physician has two patients who experienced that. That physician could then click on that highlighted number 2 and go get the actual information about the two patients in case he or she wanted to see what more could I do to improve. Even though I'm below the national

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rate, what more can I do to improve.
Q. Why don't we go on to slide 3. And what does slide 3 show? It says "Hospital acquired conditions." What is a hospital-acquired condition?
A. So no one wants to have -- go into the hospital as a patient and get a hospital-acquired condition, such as a foreign object retained after a surgery, which was the first one there. So these are also a national comparison. And this physician can look at this and see how do I compare nationally with these hospital-acquired condition rates.
MR. KEITH: Your Honor, I just will object here only because I want to clarify. As we did when we presented our screen shots, I assume these are being presented to show the functionality, not for proof of the truth of the statistics cited here.
MR. ETTINGER: Since this is one doctor, we don't even know who he is, I think that's a fair conclusion.
THE COURT: It's done only to essentially illustrate how the system works?
MR. ETTINGER: Yes, Your Honor. We will say, "Dr. Anonymous has achieved great results." That's going to be our argument. Sorry.
BY MR. ETTINGER:
Q. So you just explained what hospital-acquired conditions are, Dr. Polk?

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A. I think I did.
Q. Yep. Okay. And so, again, this allows this physician to determine if he has got any problems there and can do something about them if so?
A. And they can, again, drill down on their highlighted patients if they want to see there is more opportunity for improvement.
Q. Okay. Why don't we go on to slide 4, then. What kind of information is on slide 4?
A. Well, this looks at a broad level of costs and also length of stay and what are called "avoidable days."
Q. So these are cost measures rather than quality measures; is that right?
A. Yes. Some would call length of stay a quality measure, but some would call it an efficiency measure also. Otherwise, these are cost metrics and charge metrics.
Q. Again, does this apply to the individual physician?
A. Yes. This is this individual physician's data.
Q. Okay. And again, this is data that's provided to independent doctors as well as employed doctors?
A. Right. And it's important to note that the comparison is other physicians who care for similar patients.
Q. And so this doctor is not doing as well on the

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cost measures as he or she was doing on the quality measures; correct?
A. That is correct.
Q. And so how can this doctor use this information?
A. Well, you can drill down further in the tool and get actually to an item charge. And in comparison with your peers, you can ask questions and decide why is it that your costs are the way they are.
So we encourage that dialogue, and it does happen.
Q. So why don't we go on to the other demonstrative on Explorys. That's No. 3070, Your Honor.
And again, Explorys, this is the system that will be used for the Alliance network; is that correct?
A. Yes.
Q. And what are the slides that -- the Explorys slides that we're going to go through?
A. So this first slide -- and again, this is --
Q. Before you go into the details of the slides, Dr. Polk, just say generally what these slides represent.
A. Okay. Generally what these slides represent are ways that physicians and caregivers can look at the information and use it for population health management.
Q. Are these slides -- do these slides reflect actual data?
A. No. It is synthetic.

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Q. Why is this synthetic? Is there actual data up yet for the Alliance on Explorys?
A. We are just now seeing some actual data in the user validation testing period.
Q. But are you familiar with synthetic slides of this sort as well?
A. Yes.
Q. How are you familiar with them?
A. I have seen them in demos of the tool.
Q. Have you also been involved in reviewing the ongoing user validation testing?
A. Yes.
Q. So the Crimson data -- you said the Crimson slides were limited to hospital-based care. Is that true of the Explorys data or not?
A. Explorys will bring in ambulatory or outpatient care also.
Q. So physicians' offices, too?
A. Yes.
Q. And will it apply to both employed and independent physicians?
A. Yes.
Q. And so looking at this slide, which I guess is slide No. 2 since the cover page was slide No. 1, what does it show?

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A. So this shows different clinic -- fictional clinic sites and fictional physicians and their performance. The far left column is the diabetes metrics that they are being judged upon. And if there is a green check, it means that they have met the target. If there is a red X, it means they have not met the target. It also shows the number -- the percentage of patients in that population who have met that target.
Underneath each number is a small chart icon which allows you to get into a trend chart. So if a physician wants to see what the trend is over time, they can. And then the person icon beneath the numbers actually will pull up the names of the patients who are involved in that metric.
Q. So taking a look at, for example, the fourth metric on slide 2, HbA1c, and taking a look at the third column, the fictitious Dr. Baldwin, how is she doing administration -- on administration of HbA1c?
A. She is not doing well.
Q. And how do you tell that?
A. 9.1 percent with the red X.
Q. How would Dr. Baldwin -- if she got this result, how would she use this to try to improve the care she provides?
A. Well, first, I would question does Dr. Baldwin

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understand the definition. And I think Dr. Baldwin might go to that fourth one and hover over it to get the definition of it so that they truly understand what the target is and what the numerator and denominator is.

Q. Why don't we go to slide 3. What does this show us?

A. This shows us exactly that. They can highlight over it, find out what the target is, the source, whoever the steward is of the target -- it's the NCQA -- and how the metric is defined.

Q. Why don't we go on to slide 4. So she's learned the metric. What does slide 4 tell her?

A. So what this tells her is the patient population -- and it's cut off at the top, but you can see at the top there is a drop-down box, and she has selected the nonadherent population, and there is 20 patients in that nonadherent category, and so this is the list of 20 patients.

Q. What do you mean by nonadherent?

A. In other words, they are not hitting that metric of A1c less than 8 percent.

Q. And why would she want to look at the nonadherent population?

A. Well, she would want to find out what she could do differently, what changes she could make to bring about

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improvement in these cases, and try and figure out why they fell through the cracks.

Q. So the top patient there is Amy Bowers. Can she drill down further, Dr. Baldwin, and learn about particular patients and what their situation was?

A. Right. She clicks on the green icon in the middle of the far left column under actions.

Q. And why don't we go to slide 5. What does that show us?

A. What this shows us is the virtual chart of this fictitious patient Amy Bowers. And you can see on the drop-down list the many different things that come up in the virtual chart: a list of the encounters -- and that's the field that you're seeing here now -- the diagnoses the patient has had, what procedures were done, social history, medications, allergies, and other things.

Q. So how can Dr. Baldwin use this information to --

A. Well, she could go to the last encounter and see what the discussion was to find out why an A1c was not drawn, or she could go to the procedure list and see if it was drawn or when the last one was drawn and see if she truly needs to repeat it.

Q. And above -- where it says Amy Bowers in the upper left, above there, there are a couple tabs that say "EHS Meditech" and "EHS claims." What does that refer to?

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A. Right. Those are sources of data that go into Explorys in this hypothetical example; Meditech being an EMR, and the claims being a claims database.

And I think this really shows the power of Explorys because in the Saint Alphonsus Health Alliance, what you will see across the top there will be all the EMRs that are involved because they will be sources of data. You will have Idaho Health Data Exchange as a source of data. The ADT information, you will have payors listed across the top as sources of information.

And so all of those sources come in. And that's really valuable, say, when you are looking for a procedure because the physician could go into the procedure tab and could even see procedures that are done outside the Saint Alphonsus Health System.

Q. And is this kind of information that we see on these slides what you expect to see on the actual data that Explorys provides to the Alliance?

A. Yes.

Q. So will each Alliance physician ultimately be able to access --

A. Yes.

Q. -- slides like this as to his or her patients?

A. Yes. Excuse me.

Q. Let's skip some, just to move along, but talk

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about a couple more of these slides very quickly.

How about slide 10. What does slide 10 show?

A. Explorys has a lot of graphical representations, and this is just one of many graphical representations of how a physician is performing on a metric having to do with controlled blood pressure.

So they can see their performance score on the far right, the number of patients that apply to it. And then the color coding is meant to easily tell the physician where they're in top quartile or the 50th to 75th percentile, which would be yellow. The orange is 50th to 25th. And the red would be 25th percentile and lower.

Q. And how would this be used by one of the physicians that are listed here?

A. Well, they can look at their peers and see who is doing very well, give them a phone call. They can ask questions especially about, well, if Dr. So-and-So is in my office and they are doing better than me, what am I not doing correctly? Or there could be variation by clinic sites. Some clinic sites may do this better than other clinic sites.

Q. Why don't we go on to slide 11 finally.

A. Okay.

Q. What does this show, Dr. Polk?

A. This is a representation by site. So it could be

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clinic sites or hospital clinics or whatever, showing their performance.

Q. Do you believe these data analytics tools, this information is going to be beneficial to physicians in terms of medical care, first of all?

A. Oh, absolutely, yes.

Q. Will it also be beneficial in terms of the success of their practices, do you believe?

A. Yes.

Q. An earlier witness talked about the WhiteCloud registry and how his use of it resulted in a patient getting a mammogram and having her life saved.

In your view, would that be relevant or irrelevant to the success of the physician's practice? Of course, it was wonderful for that patient, but how would that affect the success of the physician's practice in your view?

A. We all want to be known for doing a good job. I know in my own practice, when I did a good job, people would talk to other people about it. And the word of mouth is very strong in terms of creating referrals and creating business. So it -- when you do well, the word gets out.

Q. And if the data analytics tool helped you do well, do you think that will help physicians do well in terms of treating patients? Do you think it will also help them do well financially?

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A. Yes.

Q. Why don't we talk briefly about a couple other subjects. Are you familiar with the Idaho Health Data Exchange?

A. I am.

Q. And does Saint Alphonsus use the Idaho Health Data Exchange?

A. We both send information and receive information from IHDE.

Q. Do Saint Al's physicians find it useful, in your experience?

A. Very much so.

Q. Can you give an example or two?

A. It's commonly used in -- among the medical group to get information about a new patient coming into the clinic that maybe they have never seen before but has been seen in other care sites.

It's commonly used if a patient may become ill and is cared for in the emergency department and you need those ED records within about two days, because the uploads -- at least our Saint Alphonsus Health System, the uploads are immediate. So that information is immediately available. All the provider needs is an Internet browser and a password and the name of the patient and a date of birth, and they can get that information.

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Q. Are you personally familiar with the Idaho Health Data Exchange?

A. I am.

Q. How have you become personally familiar with it?

A. I was on the Quality Health Planning Commission that started the Idaho Health Data Exchange. We commissioned it. The Health Quality Planning Commission is a body that the legislature set up. It's governor-appointed. And our job was to improve health information flow in the state to improve the care of the citizens of Idaho, and our second job is to improve the quality of care as well.

And I'm still on the HQPC as the chair. So we spent quite a bit of time in our first few years on the HQPC trying to set up an information exchange, health data exchange, that will allow providers easy access to the information being provided.

Q. And the "HQPC," that's shorthand for the Health Quality Planning Commission?

A. Yes, sir.

Q. And does that continue to oversee the Idaho Health Data Exchange?

A. Yes, we do. We're mandated by statute to receive reports every three months.

Q. And have you been on the board of the Idaho Health

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Data Exchange as well?

A. Yes, I'm the current chair -- no. Excuse me. I got that mixed up.

Q. You said you're the chair of the HQPC.

A. I was on the board of IHDE, yes. Sorry.

Q. Didn't want to promote you unnecessarily.

A. Thank you.

Q. Can the Idaho Health Data Exchange in your experience provide transcribed notes to users?

A. It does.

Q. What's the cost to a member to get information from the Idaho Health Data Exchange?

A. $390 a year.

Q. Let me ask you just about one other topic. Let's suppose -- there has been testimony already that the Saint Alphonsus Health Alliance is nonexclusive, that physicians can belong to the Alliance as well as other networks.

If a physician group belongs to the Alliance and other networks as well, do you think that will create difficulties in terms of those physicians achieving the quality goals of the Alliance?

A. No, I do not.

Q. And why not?

A. The -- if they're in doing clinical integration work with different networks, the metrics, the quality

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measures are going to be very similar. We're all using the NCQA HEDIS metrics. They're pretty much the same ones, same chronic diseases that we're trying to deal with -- obesity, diabetes, hypertension. And so it's pretty much the same basic set, and so I don't see any conflict. It's just patient management and how you access information.

MR. ETTINGER: I have nothing further at this time. Thank you.

MR. KEITH: I can be very brief.

THE COURT: Counsel, my thought was to give counsel ten minutes gratis time to -- can you wrap it up in that time?

MR. KEITH: Absolutely.

THE COURT: My recollection is Dr. Polk -- where the Explorys issue came up, you were going to possibly submit rebuttal or I guess it would be surrebuttal.

MR. KEITH: That's possible, although we will see if perhaps we can avoid that in ten minutes.

THE COURT: All right. And I think Mr. Metcalf indicated there are 28 minutes, you have roughly 29 minutes of video designations. So presumably that may cover it. So your time begins now. Sorry, Mr. Keith. I don't --

CROSS-EXAMINATION

BY MR. KEITH:

Q. Good afternoon, Dr. Polk.

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A. Hi.

Q. I listened very closely, since I have no time, for any mention of an effort or initiative that you were describing that would relate directly to the Saltzer primary care physicians who work not in hospitals but in their own clinics, and I think I heard two. One was the Saint Alphonsus Health Alliance; the other was relatedly the use of Explorys.

Did I miss anything in terms of what you testified to that relates to the Saltzer physicians and their primary care clinics?

A. I'm not sure I understand your question.

Q. Well, you talked about SCIP measures. You talked about Crimson. You talked about the 100,000 Lives. All of those relate to hospitals, don't they?

A. No.

Q. They relate to care in the hospitals?

A. Not always, no.

Q. SCIP is surgical care improvement?

A. There are SCIP outpatient metrics, yes.

Q. Okay. And were the Saltzer primary care physicians involved in those SCIP metrics?

A. I'm not sure I understand what your question is.

Q. My question is: Were the Saltzer physicians tracked under the SCIP program that you articulated?

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A. If they were surgeons, the Nampa hospital would track them, yes.

Q. If they are primary care, no?

A. Unless they did surgical procedures, in which case they would be.

Q. You're not aware that the primary care physicians at Saltzer do any substantial number of surgical procedures, are you?

A. Actually, a primary care doctor could do procedures. I believe colonoscopies fall under the SCIP measures.

Q. So let's talk about the Alliance. When you sat for your deposition, you told me the Alliance is not yet clinically integrated. Is that -- do you remember that testimony?

A. Yes.

Q. And it's not clinically integrated today, is it?

A. Yeah, correct.

Q. And you're not going to venture a guess right now, are you, as to when the Alliance will, in fact, be clinically integrated?

A. Yes, I will.

Q. Oh, you will? When is that?

A. Sometime in 2014.

Q. Sometime in 2014?

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A. Mm-hmm.

Q. And the Explorys tool, you said, was rolling out in December-January -- this coming December and January?

A. For the first few groups, yes.

Q. You had earlier told me it was September-October; right?

A. We are a couple of months behind.

Q. Things slip, right? Right?

A. Yes. We are behind.

Q. And you -- you articulated that the Primary Health medical group will be the first group attached to Explorys or with whom there is a fee to Explorys. Has that work already begun, that is, generating the feed from Primary Health Medical Group's ECW system to Explorys?

A. I don't think it's started as of today, no.

Q. What's the estimate on what it will cost?

A. I don't -- I don't have that information.

Q. You don't know?

A. No.

Q. And what's the estimate on the number of man or person hours that it will take to connect those two systems?

A. I don't have that information either.

Q. And you mentioned IHDE and connecting IHDE to Explorys. That hasn't occurred yet, has it?

A. That's a work in progress.

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Q. And that's something that takes money, time, and a champion in administration; right?
A. Yes.
Q. All of those things?
A. Mm-hmm.
Q. And for every data system that you want to bring into Explorys, that's true? You need money, time, and an administrative champion; correct?
A. You need leadership, yes.
Q. And money; right?
A. Well, I would assume so, yes.
Q. And somebody's time; correct?
A. Yes.
Q. Okay.
A. Of course.
Q. And what's the estimate as you sit here today of when all of the Alliance members will be connected into the Explorys tool?
A. I don't have that number. I know that primary care will be rolled out to primary care physicians in the Alliance first.
Q. And when will they have it, the primary care physicians?
A. Probably sometime in 2014. I don't have the exact dates in my memory.

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Q. And how many individuals are staffed either at -- from Saint Alphonsus or from some third-party vendor on getting the Explorys system incorporated with the right set of data?
A. I don't have that information.
Q. And how much money has been allocated to the initiative to connect Explorys to all of the various data sets you described?
A. I don't have that information either.
Q. Okay. You're not the expert on the rollout in terms of the --
A. Just the accountable executive to make sure it happens.
Q. So someone else would probably be better to talk to on exact details of how things are going to be incorporated, how long it will take, what it will cost; correct?
A. Well, I have to make sure, as accountable executive, that those things happen. But I have a team of people that are doing it who are doing a good job, and then they tell me how it's going, and I either remove barriers or talk to my boss and say it's not going well or it is going well.
Q. But day to day, you're not the person in charge, I take it, to --

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A. I don't do the day-to-day operations. Not at the management level, no.
Q. Can I go directly from Explorys to my EHR if I'm not on -- say I'm on eClinicalWorks, I'm Primary Health Medical Group. Can I go right from Explorys to my EHR, one click?
A. I don't know what "my EHR" is.
Q. My electronic health record, my own eClinicalWorks system.
A. Okay. Can you rephrase/restate your question?
Q. Sure. If I'm on Explorys and I see a patient of mine and I don't think she should be in that bucket because I know I gave her her A1c test, can I click through to my own electronic health record, my own ECW record natively?
A. From Explorys?
Q. From Explorys.
A. Probably not, but you already have information from eClinicalWorks in Explorys.
Q. But if I wanted to fix a record, for example, in eClinicalWorks, I would have to actually get out of Explorys, go to my eClinicalWorks, and fix it; correct?
A. Well, from a business standpoint, we're actually creating a portal so that we can do it without another sign-on.
Q. So it's another plan in the works?

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A. Correct, it is.
Q. And you mentioned that you thought the whole thing would go pretty smoothly. Now, obviously, you haven't started yet. So that's really what you have been told by Explorys; correct?
A. No.
Q. No? You have personal experience implementing Explorys?
A. Well, just since last summer.
Q. And that's with the SAMG physicians; right?
A. I'm not sure I understand your question.
Q. Well, you're implementing Explorys, but it's with the employed physicians of Saint Alphonsus; correct?
A. Well, Saint Alphonsus Medical Group is 25 percent of the Alliance. So we're implementing it for the Alliance.
Q. But, so far, just to the employed physicians within the Alliance?
A. Just in the user validation testing which is happening now.
Q. Because it's easier to do that with your employed physicians because they're all in the same system; right?
A. They're in foreign EMRs, Cerner and NextGen, but we have already implemented those. They're in Explorys. So is our ADT system. And we're starting to get the lab features in it.

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Q. You also rolled out MedVentive to your SAMG physicians, too, didn't you?
A. That was before the Alliance was created, yes.
Q. Well, but there is a pattern here. You roll these things out to your employed physicians first; correct?
A. I think the normal standard in implementing these big systems is to do it with a pilot group.
Q. And the pilot group were your employed physicians?
A. User validation testing becomes very important. And then actually anytime you -- as you expand it, you have to continue to do the user acceptance training -- testing and training. That's just the way it is.
Q. Well, that's interesting but not an answer to my question. My question is: In each instance which you've rolled out a registry, you have rolled it out to your employed physicians first; correct?
A. The Alliance didn't exist when we rolled out MedVentive. I'm not trying to be combative. I am trying to anticipate your question and give you the right context.
Q. Fair enough. When you had a choice with Explorys, you decided to implement with your employed physicians first; correct?
A. No. We're rolling it out to -- I mentioned it earlier -- three of the SAMG sites and Primary Health Medical Group. We're just doing user testing now. That's

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not rolling it out.
Q. Oh, you haven't even rolled it out to the employed physicians on any broad basis yet?
A. We are going to roll it out to the people I said earlier who we would roll it out to.
MR. KEITH: Thank you. No further questions.
THE COURT: Any redirect?
MR. ETTINGER: No, Your Honor.
THE COURT: You may step down. Thank you.
Any further rebuttal?
MS. DUKE: Just those videos that we mentioned, Your Honor, that we will submit. And there are still exhibits and demonstratives that are being negotiated between both parties.
THE COURT: Counsel, I need to leave if at all possible. I was hoping perhaps Mr. Metcalf could work with you, and then you could file something in writing in terms of your agreement on exhibits. And if you can't agree, you can indicate where the disagreement is and submit something in writing and I can resolve that. Is that agreed?
MR. KEITH: Yes.
MS. DUKE: Yes, Your Honor, that's great. And one housekeeping. 3130 was the demonstrative for Dr. Dranove that you wanted us to put on the record.
THE COURT: Thank you very much. I think we

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identified the demonstrative -- yes, we did -- for Dr. Polk as well.
And then, Ms. Gearhart, I believe there were some depositions that I directed to be published and we have not yet done so.
THE CLERK: Correct, Your Honor. The deposition of David Dranove taken August 19th, 2013; the deposition of Deborah Haas-Wilson taken August 23rd, 2013; the deposition of Steven Williams taken March 22nd, 2013; the deposition of Lisa Ahern taken August 19th, 2013; and the deposition of Harold Kunz taken June 11, 2013, are published.
THE COURT: All right. Thank you.
Counsel, I understand that briefing will be due November 1st and oral argument November 7th. And counsel have made inquiry about having more than three hours allotted. I think given four weeks of trial, I think that's probably in order.
The problem, of course, is my calendar. I know the next day I have a full day Markman hearing in a patent case. Ms. Gearhart will groan, but we'll have to find some time to figure out -- we may need to start early. I don't know. We will just have to sort that out, but I'll let you negotiate that with Mr. Metcalf as far as the time. We can give you more time, but it has to be done that day. And we'll just have to see where else we are in terms of other sentencings

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or what have you.
Is there anything else, Counsel?
MR. POWERS: No, Your Honor.
THE COURT: It is my normal practice at the conclusion of a trial to come down and shake hands with counsel, and I will have to do that verbally because I do need to get on the road to Pocatello for a docket tomorrow.
I just want to express my appreciation for the absolute highest quality of lawyering that I saw in this courtroom. I do feel badly that the public didn't have the full opportunity to watch the entire trial because I think it truly was of the first order.
I was fortunate I think some of the students of my class were able to sit in for part of the course, and I think that was a -- or for part of the trial, and they were I think duly impressed.
Thank you, Counsel. We will see you on November 7th for oral argument. We'll be in recess.
(Trial concluded at 3:37 p.m.)

REPORTER'S CERTIFICATE

I, Tamara I. Hohenleitner, Official Court Reporter, County of Ada, State of Idaho, hereby certify:

That I am the reporter who transcribed the proceedings had in the above-entitled action in machine shorthand and thereafter the same was reduced into typewriting under my direct supervision; and

That the foregoing transcript contains a full, true, and accurate record of the proceedings had in the above and foregoing cause, which was heard at Boise, Idaho.

IN WITNESS WHEREOF, I have hereunto set my hand October 22, 2013.

-s-
Tamara I. Hohenleitner
Official Court Reporter
CSR No. 619